

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5248

## CERTIFICATE OF DEATH

05240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 Woodlawn Ave</b>				d. STREET ADDRESS <b>124 Woodlawn Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First	Middle	Last	4. DATE OF DEATH <b>JULY 1 MAY 9 1958</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1875</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>GEORGE AISQUITH</b>			14. MOTHER'S MAIDEN NAME <b>MARY IRELAND</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lucy B. Tucker- Sister- Same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) DUE TO (c)								
<i>Cardio Vascular Failure</i> <span style="float: right;">Sudden</span> <i>Myocarditis &amp; Valvular Disease</i> <span style="float: right;">Several yrs</span> <i>General Arterio Sclerosis</i> <span style="float: right;">Several yrs</span>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>40 Franklin St, Annapolis</b>		(County) <b>Anne Arundel</b> (State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>May 7<sup>th</sup>, 1958</b> to <b>May 9<sup>th</sup>, 1958</b> that I last saw the deceased alive on <b>May 9<sup>th</sup>, 1958</b> , and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. Oliver Purvis</i>							ADDRESS (Street, city or town, state) <b>40 Franklin St, Annapolis</b>	DATE SIGNED <b>5-10-58</b>
PHYSICIAN'S NAME (Type) <b>J. OLIVER PURVIS M.D.</b>		40 FRANKLIN STREET ANNAPOLIS MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 12, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>HOPE CHAPEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>EDGEMEATER, MARYLAND</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Oliver Purvis</i>		ADDRESS <b>HOPPING FUNERAL HOME ANNAPOLIS, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAY 13 '58</b>			24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>	

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME: MARY ANN TAYLOR  
DATE OF DEATH: 03/27/1991

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 9 Film G229 6-1-58 et  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

05241

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>10</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		d. STREET ADDRESS <b>407 Washington Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>407 Washington Street</b>				d. STREET ADDRESS <b>407 Washington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ANNA M. ALEXANDER (ALSO MARGUERITE PARKIN)</b>		First <b>ANNA M. ALEXANDER (ALSO MARGUERITE PARKIN)</b> Middle <b>M</b> Last <b>A.</b>		4. DATE OF DEATH <b>May 23</b>		Month	Day	Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 17, 1892</b>	9. AGE (In years last birthday) <b>65 66</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Night Supervisor</b>		11. BIRTHPLACE (State or foreign country) <b>Pittston, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Gilbert Alexander</b>		14. MOTHER'S MAIDEN NAME <b>Marie Schneider</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 212-32-2981</b>		17. INFORMANT <b>Mr. Frederick J. Parkin- Husband- same as # 2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2</b>		DUE TO <b>Carcinoma of the gall-bladder and pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Arlington National Cemetery</b>		20f. (City or town) <b>Arlington, Va.</b>		(County) <b>Arlington Co.</b> (State) <b>VA</b>
21. I certify that I attended the deceased from <b>June 1957</b> , to <b>May 23, 1958</b> , that I last saw the deceased alive on <b>May 20, 1958</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Severna Park, Maryland</b>		DATE SIGNED <b>5-24-58</b>		
ACTUAL SIGNATURE <b>Francis I. Codd</b>		M.D. <b>Francis I. Codd M.D.</b>						
PHYSICIAN'S NAME (Type) <b>Francis I. Codd M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 27, 58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State) <b>VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred E. Codd</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5283

## **CERTIFICATE OF DEATH**

05242

Reg. Dist. No. 1

1. PLACE OF DEATH o. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Point</b>		b. COUNTY <b>Charles</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 1, Box 432 A</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Richard</b>		First	Middle <b>Baily</b>	Lost	4. DATE OF DEATH <b>May 2, 1958</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1887</b>		9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self - emp.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>000-00-0000</b>		17. INFORMANT <b>Ralph Baily, Rock Point, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <b>CORONARY ATHEROSCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH <b>None -</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)		
21. I certify that I attended the deceased from <b>1-15</b> , 19 <b>58</b> , to <b>5-2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-29</b> , 19 <b>58</b> , and that death occurred at <b>7:40A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>201 BTA BLVD, GLEN BURNIE, MD</b> DATE SIGNED <b>5-2-58</b>								
ACTUAL SIGNATURE <i>Leon C. Perry</i>	PHYSICIAN'S NAME (Type) <b>LEON C. PERRY M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Nanjemoy Baptist</b>	22d. LOCATION (City, town, or county) <b>Charles County, Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jones &amp; Kirkley</i>		ADDRESS <b>Hopping and Kirkley, Glen Burnie, Md.</b>	24a. REC'D BY REGISTRAR <b>MAY 5 1958</b>	24b. REGISTRAR'S SIGNATURE <b>Paul J. Jones</b>				

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/tranit permit. Then please remove carbon paper. Pages 1 and 2 should be saved with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH		
JOHN D. HORN	50	MALE	APRIL 15, 1945	10:00 A.M.	HEART DISEASE		
ADDRESS	STATE	CITY	ZIP	PHONE NUMBER	TELEGRAMS TO		
1234 FAIRFIELD DR.	WI	MILWAUKEE	53207	414-555-1234	WISCONSIN STATE DEPARTMENT OF DEFENSE		
RELATIONSHIP	NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP	NAME		
WIFE	MARY E. HORN	1234 FAIRFIELD DR.	414-555-1234	SON	JOHN HORN JR.		
WITNESSES	NAME	ADDRESS	PHONE NUMBER	WITNESSES	NAME	ADDRESS	PHONE NUMBER
JOHN HORN	1234 FAIRFIELD DR.	414-555-1234	MARY E. HORN	1234 FAIRFIELD DR.	414-555-1234		
DATE ISSUED	APRIL 15, 1945	BY	JOHN HORN	APPROVED	JOHN HORN	APPROVED	JOHN HORN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5250

## CERTIFICATE OF DEATH

05243

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>X Churchton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>/</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b>		4. DATE OF DEATH <b>Bains</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 29, 1958</b>	
9. AGE (In years lost birthday) yrs. <b>20</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Address</b>	
13. FATHER'S NAME <b>Luther Luke Bains, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Arveta Cyrilla Nick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Pneumothorax</b> 760.5 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO <b>Intracerebral Hemorrhage, Sublectus</b> (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>2 h 15 min</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(110-CHAY ST ANN ARBOR MI 48105)</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/29/1958</b> to <b>5/29/1958</b> , that I last saw the deceased alive on <b>5/29/1958</b> , and that death occurred at <b>5/29/1958</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D.</b>	
ACTUAL SIGNATURE <b>R. Rehwald</b>		DATE SIGNED <b>5/30/58</b>	
PHYSICIAN'S NAME (Type) <b>Amil A. Johnson</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried May 31/58</b>	
22b. DATE THEREOF <b>5/31/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Matthews</b>	
22d. LOCATION (City, town, or county) <b>Shadyside</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amil A. Johnson</b>		24a. REC'D BY REGISTRAR DATE JUN 3 '58	
ADDRESS <b>Annapolis</b>		24b. REGISTRAR'S SIGNATURE <b>Av. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05244

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5251 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md a a					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY					
Annapolis				Davidsonville Md		a a					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS							
a a General Hosp											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Female		White	Never Married	Mar. 25. 1909	49	5-	13	19 58			
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	Mar. 25. 1909	49	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
House wife		Home		Hyattsville Md		U. S. A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address							
Philip Jones		Isabelle Henderson				(2)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
170x				Warren H. Bamford		Cardiac failure		2 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b)		DUE TO				Extensive lung metastases		9 months			
{		DUE TO				Cancer left breast		2 1/2 years			
(c)		DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from February 19, 1958, to May 13, 1958, that I last saw the deceased alive on May 13, 1958, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)								DATE SIGNED	
PHYSICIAN'S NAME (Type)		H. Harold R. Bohlman M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)				(State)	
Burial		5-15-58		Methodist Church Yard		Friendship Md					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE					
John M. Taylor Sons		Annapolis Md		MAY 19 '58		W. E. Smith					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Name of Physician

Place of Death

L

Date

Place

of Birth



Signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5252 CERTIFICATE OF DEATH

Reg. Dist. No.

05245

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>a a General</i>	e. STREET ADDRESS <i>637 Chase</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>ROBERT</i>	Middle <i>C.</i>	Last <i>BEAN</i>
4. DATE OF DEATH	Month <i>5</i>	Day <i>13</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-1905</i>
9. AGE (In years last birthday) <i>53 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General Contractor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Boulder Homes Inc.</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Harry E. Bean</i>	14. MOTHER'S MAIDEN NAME <i>Pearl Johnson</i>	Address <i>(2)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Frances S. Bean</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), (c) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH MINUTES -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>G. FRANKLIN ST.</i> (County) <i>Annapolis</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>SEPT 1958</i> to <i>MAY 13 1958</i> that I last saw the deceased alive on <i>APR 16 1958</i> , and that death occurred at <i>8:35 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Richard N. Peeler</i> M.D. ADDRESS (Street, city or town, state) <i>68 FRANKLIN ST.</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>RICHARD N. PEELER</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>5-16-58</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i> 22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>May 19 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. L. Gedrich</i>

**CERTIFICATE OF DEATH**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05246

5253

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>A.A.</i>		
b. CITY OR TOWN (If outside corporate limits, write BOROUGH and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>		d. STREET ADDRESS <i>133 Franklin St</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>33 Franklin St</i>				d. STREET ADDRESS <i>133 Franklin</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>Elizabeth</i>	Middle <i>L.</i>	Last <i>Beattie</i>	4. DATE OF DEATH <i>May 9 1958</i>	Month <i>May</i>	Day <i>9</i>	Year <i>1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-27-1877</i>	9. AGE (In years last birthday) yrs. <i>81</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pittsburgh Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Harrison L Lutz</i>		14. MOTHER'S MADDEN NAME <i>Blanche Reynolds</i>		Address <i>Mrs Evelyn Singas (2)</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500. Congestive heart failure</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized arteriosclerosis</i>		DUE TO (b) <i>Generalized arteriosclerosis</i>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <i>July 1953</i> , to <i>May 1958</i> , that I last saw the deceased alive on <i>5/8/58</i> , 19 <i>58</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John H. Hedeman</i> PHYSICIAN'S NAME (Type) <i>JOHN H. HEDEMAN</i>		ADDRESS (Street, city or town, state) <i>68 Franklin St Annapolis, Md</i>		DATE SIGNED <i>5/9/58</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-11-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Shippensburg Pa.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John W. Taylor</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05247	
5284 CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>					b. COUNTY <b>District of Columbia</b>						
c. LENGTH OF STAY IN lb <b>16 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Children's Center, Laurel, Md.</b>					d. STREET ADDRESS <b>330 L Street S.E.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frederick Allen Bell</b>					First	Middle	Last	4. DATE OF DEATH <b>May 18 1958</b>	Month	Day	Year
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 15, 1952</b>	9. AGE (In years last birthday) <b>5 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --			10b. KIND OF BUSINESS OR INDUSTRY --			11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Henry Bell</b>					14. MOTHER'S MAIDEN NAME <b>Essie Mae Dent</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --			16. SOCIAL SECURITY NO. --			17. INFORMANT <b>Children's Center, Laurel, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aspiration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>convulsive disorder</b> DUE TO lying cause lost. (c) <b>cerebral birth injury</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs birth present</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>epilepsy</b> <b>mental deficiency</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington, D.C.</b>		(County) <b>D.C.</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from <b>May 2, 1958</b> , to <b>May 18, 1958</b> , that I last saw the deceased alive on <b>May 18, 1958</b> , and that death occurred at <b>6:15 AM</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>Wilfred R. Ehrmantraut, M.D., Children's Center, Laurel, Md.</b>	DATE SIGNED <b>5/19/58</b>
ACTUAL SIGNATURE <b>Wilfred R. Ehrmantraut, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Wilfred R. Ehrmantraut, M.D.</b>								CHILDREN'S CENTER, LAUREL, MD. 5/19/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>			22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Malvina S. Sepey Inc.</b>					ADDRESS <b>424-P St NW</b>					24a. REC'D BY REGISTRAR DATE <b>MAY 27 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Albert Leach</b>



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05248

5285

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>21yr. 9m. 25d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1015 Argyle Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Mazie</b>	Middle <b></b>	Last <b>Black</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>25</b>	Year <b>19 58</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1905</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Black</b>		14. MOTHER'S MAIDEN NAME <b>Cecilia Stuart</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Dehydration with Gastro-Intestinal Hemorrhage</b> DUE TO (c) <b>Cancer of the Breast</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>5/25</b>	(County) <b>19 58</b>
21. I certify that I attended the deceased from <b>July 1956</b> to <b>5/25 1958</b> , that I last saw the deceased alive on <b>5/25 1958</b> , and that death occurred at <b>11/25 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp, M.D.</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>					
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>5/26/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal 5-27-58</b>		22b. DATE THEREOF <b>5-27-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Edwd. Mc. Dowell</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Pease #108 Wash. St. Anna, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE <i>Aschuck</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G229 6-2-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

05249

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		5254		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ann Arbor</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		b. COUNTY <i>Anne Arundel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U-M General Hospital</i>		e. STREET ADDRESS <i>x Gambrell's</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print) <i>Alexander</i>		First	Middle	Last	4. DATE OF DEATH Month Day Year <i>May 14 1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Approx.</i>	9. AGE (In years last birthday) yrs. <i>80</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>(Unknown) Agin</i>		14. MOTHER'S MAIDEN NAME <i>(Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Joseph Bogdanowicz Son of #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pathomimicar Atherosclerosis</i> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral atherosclerosis</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 11</i> , 1958, to <i>May 14</i> , 1958, that I last saw the deceased alive on <i>May 13</i> , 1958, and that death occurred at <i>545</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John L. Hedeman</i> PHYSICIAN'S NAME (Type) <i>John L. Hedeman</i>		M.D.		ADDRESS (Street, city or town, state) <i>68 Franklin St.</i> DATE SIGNED <i>5/15/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 16, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Rosary Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>				(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. J. Johnson</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 22 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arch. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

81 220011248-171203 30 TRINIDAD AND BARBUDA GOVERNMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05250

Item 20 Film 228 5-14-58 ams

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>3</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>		d. STREET ADDRESS <b>1 Annapolis, Maryland</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Academy</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Richard Laurence BOGNANNI</b>		First	Middle	Lost	4. DATE OF DEATH <b>May</b>	Month	Day	Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 25, 1937</b>	9. AGE (In years last birthday) <b>21</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Midshipman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>John P. BOGNANNI</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Teresa BOGNANNI</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>755 - 558</b>		17. INFORMANT <b>U. S. Navy Records</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>974X</b> (b) <b>Strangulation</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Investigation being conducted.</b>								Plan hanged himself with his bathrobe belt	
20c. TIME OF INJURY Month, Day, Year Hour <b>X</b> p. m. May 4 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dormitory</b>		20f. (City or town) <b>Annapolis, Anne Arundel, Md.</b>		(County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 1215 PM, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>U. S. Naval Academy, Annapolis, Md.</b>	DATE SIGNED <b>5-5-58</b>
ACTUAL SIGNATURE <b>Maynard L. Sisler</b>		M.D.									
PHYSICIAN'S NAME (Type) <b>Maynard L. SISLER, LT., MC, USN</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5-8-58</b>		22b. DATE THEREOF <b>5-8-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) <b>BALTO</b>		(State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck 5305 Bayford</b>		ADDRESS <b>5305 Bayford</b>		24a. REC'D BY REGISTRAR <b>MAY 7 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Reich</b>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5286

## CERTIFICATE OF DEATH

05251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNVILLE</b>	c. LENGTH OF STAY IN 1b <b>1</b>	b. COUNTY <b>JANE ARUNDEL</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNVILLE</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <b>CHARLES ROLAND BRADY</b>		4. DATE OF DEATH Month <b>5</b>	Day Year <b>2 1958</b>
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 29<sup>th</sup> 1890</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET CIVL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CIVL SERVICE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JAMES R. BRADY</b>	
14. MOTHER'S MAIDEN NAME <b>MARY GABLE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>4200</b>	
16. SOCIAL SECURITY NO. <b>NINA B. BRADY #2</b>		17. INFORMANT Address <b>ACUTE CORONARY OCCLUSION</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH MINUTES. <b>6 YRS.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO <b>CARCINOMA OF LUNG WITH PROBABLE BONY METASTASES</b>			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>CARCINOMA OF LUNG WITH PROBABLE BONY METASTASES</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/18</b> , 19 <b>58</b> , to <b>5/2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4/25</b> , 19 <b>58</b> , and that death occurred at <b>1 A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>RICHARD N. PEPPER</b> M.D. ADDRESS (Street, city or town, state) <b>68 FRANKLIN ST.</b> DATE SIGNED <b>5/3/58</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD N. PEPPER</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
22b. DATE THEREOF <b>5-5-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>ST. MARYS</b>	
22d. LOCATION (City, town, or county) <b>ANNAPOLIS, MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '58</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>D. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5287

## CERTIFICATE OF DEATH

Reg. Dist. No.

05252

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>3mos, 28das</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manakin</b>		d. STREET ADDRESS <b>None</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Henrietta</b>	Middle <b>Braxton</b>	Last	4. DATE OF DEATH <b>5</b>	Month <b>28</b>	Day <b>19</b>	Year <b>58</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>1874?</b>	9. AGE (In years last birthday) <b>84?</b>	IF UNDER 1 YEAR Months <b>84</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> Cerebrovascular Accident INTERVAL BETWEEN ONSET AND DEATH DUE TO Arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with Regressive C. V. A.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----	(State) -----
21. I certify that I attended the deceased from <b>January 30, 1958</b> , to <b>May 28, 1958</b> , that I last saw the deceased alive on <b>May 28, 1958</b> , and that death occurred at <b>-----</b> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>									DATE SIGNED <b>5/28/58</b>
ACTUAL SIGNATURE <i>Ludwig Benedict</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>		Crownsville State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/1/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>CHARLES WESLEY</b>		22d. LOCATION (City, town, or county) <b>MANOKIN</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Glavin Jr.</i>		ADDRESS <b>Princess Anne Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Albert Joseph</i>			

STATE OF SOUTH DAKOTA

CERTIFICATE OF DEATH

T. J. Farnum

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5288

## CERTIFICATE OF DEATH

Reg. Dist. No.

05253

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		<i>14 X - 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Gilbert</b>	Middle	Lost <b>Brooks</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>7</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>1905</b>	9. AGE (In years lost birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b> </b>	IF UNDER 24 HRS. Days <b> </b>	Hours <b> </b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b> </b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b> </b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CNS Syphilis</b> DUE TO (c) <b>Meningo-Encephalitic Type</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>491X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b> </b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/6/</b> , 19 <b>55</b> , to <b>5/7/</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/7/58</b> , 19 <b>58</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Hildegard Reissmann</b> M.D. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Maryland</b> DATE SIGNED <b>5/8/58</b>							
PHYSICIAN'S NAME (Type) <b>Hildegarde Reissmann, M. D.</b>		Crownsville State Hospital, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial May 12 1958</b>		22b. DATE THEREOF <b>May 12 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Henry Cem.</b>		22d. LOCATION (City, town, or county) <b>Galta</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elvyn Miller Millington Md.</b>		ADDRESS <b> </b>		24a. REC'D BY REGISTRAR <b> </b>		24b. REGISTRAR'S SIGNATURE <b> </b>	
VS A15 (4) 15M 10/57		DATE MAY 13 '58					

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - DIVISION OF VITAL RECORDS

DEATH  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5256

Item 7 Film 229 6-2-58 et

Reg. Dist. No.

05254

1. PLACE OF DEATH a. COUNTY		A.A. County		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
		MARYLAND		a. STATE	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Annapolis		b. COUNTY	Anne Arundel
		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
				10 Annapolis -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		St. J. & Gen. Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
SARAH				Brown	5 21 Day 1958 Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 23 yrs.
F		C		Nov. 24 1932	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Saleswoman				Annapolis	
12. CITIZEN OF WHAT COUNTRY?				U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Robert Brown		Marcelline Johnson Annapolis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				Marcelline Johnson Annapolis	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		multiple insurices.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
DUE TO					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
Auto accident					
20c. TIME OF INJURY Month, Day, Year Hour p. m. 5/21/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 9	
				20f. (City or town) (County) (State) Annapolis MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E. L. Whordt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/1/58	
EXAMINER'S NAME (Type) E. L. Whordt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26/58		22c. NAME OF CEMETERY OR CREMATORIAL Brent Hill	
				22d. LOCATION (City, town, or county) Annapolis	
(State) Md					
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Johnson</i>		ADDRESS Annapolis		24a. REC'D BY REGISTRAR DATE MAY 28 '58	
				24b. REGISTRAR'S SIGNATURE <i>Webb</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, or removal.

MANHATTAN STATE PENITENTIARY - ESTABLISHED 18

WEEKLY EXAMINER'S CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146	1147	1148	1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5289

## CERTIFICATE OF DEATH

Reg. Dist. No. 05255

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. George G. Meade</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 v o 1 - 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		d. STREET ADDRESS <b>4305 Groveland Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>LILLIAN</b>	Middle <b>Grove</b>	Last <b>BUTEMENT</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>6</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Dec 1885</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edmund Adams</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband Ralston Butement.</b>		Address <b>4305 Groveland Ave, Baltimore, MD</b>	
no		no					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Cerebrovascular Accident</b> 331X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO Generalized arteriosclerosis (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. 19		20d. INJURY OCCURRED While Not while at work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 April 58</b> , 1958, to <b>6 May 1958</b> , 1958, that I last saw the deceased alive on <b>3 May 58</b> , 1958, and that death occurred at <b>800 AM</b> , 1958, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8000 ADDRESS</b>					
ACTUAL SIGNATURE <i>John Robertson</i>		DATE SIGNED <b>1958</b>					
PHYSICIAN'S NAME (Type) <b>JOHN G. ROBERTSON, Capt, MC,</b>		U.S. Army Hospital, Ft Meade, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Tschirhart &amp; Sons - Baile</i>		ADDRESS <b>17</b>		24a. REC'D BY REGISTRAR <b>John J. Tschirhart &amp; Sons - Baile</b>		24b. REGISTRAR'S SIGNATURE <b>R.H. MCGILL, CWO, USA</b>	
VS A15 (4) 15M 9/55		DATE <b>6 May 58</b>		R.H. MCGILL, CWO, USA			

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#### **REFERENCES**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5290

## CERTIFICATE OF DEATH

Reg. Dist. No.

05257

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6m. 23d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whitehall</b>		d. STREET ADDRESS <b>12 X - 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Helen</b>	Middle <b>Tittle</b>	Last <b>Chaney</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>4</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>7/4/04</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver T. Tittle</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Gibson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO <b>715X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Decubital Ulcers</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>027X Syphilitic Cirrhosis of the Liver</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 11, 1957</b> , to <b>May 4, 1958</b> , that I last saw the deceased alive on <b>May 4, 1958</b> , and that death occurred on <b>11:55A M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ludwig Benedict, M.D.</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Maryland</b> DATE SIGNED					
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>		Crownsville State Hospital, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial May 7-1958</b>		22b. DATE THEREOF <b>May 7-1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Joy</b>		22d. LOCATION (City, town, or county) (State) <b>Floyd Rd. Balt Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Kurt</b>		ADDRESS <b>Jarrettsville Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>	

Trudie

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05258

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>		c. LENGTH OF STAY IN lb <b>5 years</b>		a. STATE Same b. COUNTY <b>M.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hazlet S. Chapman / Furnace Rd. Box 190</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		d. STREET ADDRESS <b>Same</b>	
3. NAME OF DECEASED (Type or print) <b>Hazel S. Chapman</b>		First	Middle	Last	4. DATE OF DEATH <b>May the 11th,</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/14</b>	9. AGE (In years last birthday) <b>43</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>224-09-0955</b>	17. INFORMANT <b>Mr. John A. Chapman (husband)</b>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b)  DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b>	(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  <i>Gustave H. Faubert, M.D.</i>	EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>5/11/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/15/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Glen Haven Cem.</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE  <i>McCully Funeral Home, 130 E. Fort Ave., Balto. 30</i>		ADDRESS <b>McCully Funeral Home, 130 E. Fort Ave., Balto. 30</b>	24a. REC'D BY REGISTRAR <b>MAY 14 '58</b>	24b. REGISTRAR'S SIGNATURE  <i>Releasued</i>	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 is to be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be filed with the Coroner's Office.

VS. A15ME  
SM 9/55

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 230 6-8-58

5258

Reg. Dist. No.

15259

1. PLACE OF DEATH a. COUNTY	Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	Maryland C. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Annapolis	
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS	905 Carrollton Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	West St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First Joseph	Middle W.	Last CHEW	4. DATE OF DEATH	Month 5	Day 4	Year 1958
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5. SEX Male	6. COLOR OF RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8-11-1933	9. AGE (in years last birthday yrs.) 25	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Communication Ch. 21. S. Army Wash. D.C.	11. BIRTHPLACE (State or foreign country) Mary S.C.	12. CITIZEN OF WHAT COUNTRY? Mary S.C.
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13. FATHER'S NAME Reginald Chew	14. MOTHER'S MAIDEN NAME Mary Hillary	Address Mary Chew - Annapolis Md.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Femur L - Lt. nonvisible 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture Skul DUE TO (c)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto struck telephone pole	20c. TIME OF INJURY Month, Day, Year Hour o.m. 5-4 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Highway.	20f. (City or town) Annapolis	(County) Anne Arundel Co.	(State) Md.
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
---

ACTUAL SIGNATURE E.L. White Jr.	DATE SIGNED 5/4/58
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EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5-8-58	22c. NAME OF CEMETERY OR CREMATORIUM Brewer Dell	22d. LOCATION (City, town, or county) Annapolis, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE William H. White, Jr.	ADDRESS William H. White, Jr., Annapolis, Md.	24a. REC'D BY REGISTRAR Date MAY 6 '58	24b. REGISTRAR'S SIGNATURE W. L. Smith	

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possible ~~watermark~~ - ~~watermark~~  
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~~watermark~~ - ~~watermark~~ ~~watermark~~

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back small - back small

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5292

## CERTIFICATE OF DEATH

Reg. Dist. No.

05260

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		
<i>Ala County Maryland</i>		<i>Maryland Ala County</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Skudmore Md		
Skudmore Md		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skudmore Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Loggin Road		d. STREET ADDRESS Loggin Road		
3. NAME OF DECEASED (Type or print) <i>Samuel</i>		First <i>S</i>	Middle <i>Clark</i>	
4. DATE OF DEATH Month <i>5</i>	Year <i>1958</i>	Month <i>May</i>	Day <i>21</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Ceb</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-12-1888</i>	
9. AGE (In years lost birthday) yrs. <i>70</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labover</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>	14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-16-3168</i>	17. INFORMANT <i>George Clark, 1803 Robinwood Rd.</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO hypertension C.V. disease (c) gen. arterio sclerosis		10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 4th</i> , 1958, to <i>5-21</i> , 1958, that I last saw the deceased alive on <i>5-14</i> , 1958, and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>45 Floraellus St, Baltimore, Md</i>		DATE SIGNED <i>5-23-58</i>
ACTUAL SIGNATURE <i>Father Roller</i>		M.D.		
PHYSICIAN'S NAME (Type) <i>Edith Rodger M.D.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-24-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Beesley 108 Wash St. Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 26 '58</i>		
		24b. REGISTRAR'S SIGNATURE <i>Reba Smith</i>		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** As his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5293

Items 9 13 11 Film G229 6-4-58 et

## CERTIFICATE OF DEATH

05262

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3. VOl-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				d. STREET ADDRESS <b>838 E. Preston Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>T</b>	Last <b>COLLIER</b>	4. DATE OF DEATH <b>May 25 1958</b>	Month <b>May</b>	Day <b>25</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>28 Jan 1886</b>	9. AGE (In years last birthday) yrs. <b>72 7/12</b>	IF UNDER 1 YEAR Months <b>72</b>	IF UNDER 24 HRS. Days <b>7</b>	Hours <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired M/Sgt</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1915-19-15</b>		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Marked pulmonary congestion and edema with areas of bronchopneumonia, bilateral</b>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>522X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Dehydration and Acidosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 May 1958</b> , to <b>25 May 1958</b> that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>0612 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>U.S. Army Hospital, Ft Meade, Md</b> DATE SIGNED <b>26 May 58</b>							
ACTUAL SIGNATURE <b>Dee J. Mc Gonigle</b>							
PHYSICIAN'S NAME (Type) <b>DEE J. MC GONIGLE, CAPT, MC, U.S. Army Hospital, Ft Meade, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 28 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bela Wiedefeld 900 E. Biddle St</b> ADDRESS							
24a. REC'D BY REGISTRAR DATE MAY 28 '58 24b. REGISTRAR'S SIGNATURE <b>John Lewis</b>							

## CERTIFICATE OF DEATH

Name of deceased		Age at time of death		Cause of death	
John W. Hause		60 years		Diseased heart	
Spouse		Sex		Color of hair	
Wife		Male		Black	
Address		Place of birth		Date of birth	
100 Main Street, La Crosse, Wis.		La Crosse, Wis.		Sept. 10, 1880	
Name and address of physician		Name and address of hospital		Name and address of funeral home	
Dr. John W. Hause, 100 Main Street, La Crosse, Wis.		La Crosse Hospital, La Crosse, Wis.		Lundberg Mortuary, La Crosse, Wis.	
Name and address of informant		Signature of informant		Signature of physician	
John W. Hause, 100 Main Street, La Crosse, Wis.		John W. Hause		John W. Hause	
Date of death		Time of death		Signature of coroner	
Sept. 10, 1948		10:00 A.M.		John W. Hause	
Signature of coroner		Signature of physician		Signature of funeral director	
John W. Hause		John W. Hause		John W. Hause	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5294

## CERTIFICATE OF DEATH

Reg. Dist. No.

05263

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>lyr. 9m. 22d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>323 Popleton Street</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Alice</b>	Middle <b>Cottrell</b>	Last <b>Commodore</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>9</b>	Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/ /1881</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress, Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>				
13. FATHER'S NAME <b>Horse Cottrell</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Ann</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address						
<b>No</b>		17. INFORMANT <b>Hospital Records</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>931X</b>										
DUE TO <b>Cerebrovascular Accident</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Generalized Arteriosclerosis</b>										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ 19 p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____		(County) _____	(State) _____	
21. I certify that I attended the deceased from <b>7/17</b> , 19 <b>56</b> , to <b>5/ 9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/9</b> , 19 <b>58</b> , and that death occurred at <b>3:25 P.M.</b> from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>Ludwig Benedict</i>									ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>	DATE SIGNED <b>5/12/58</b>
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>		Crownsville State Hospital, Md. 5/12/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5/13/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Md. Abol School</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese #108 Wash. St. Anna, Md.</i>		ADDRESS		24a. REG'D BY REGISTRAR <b>W. J. Rees</b>		24b. REGISTRAR'S SIGNATURE <i>W. J. Rees</i>				
				DATE <b>MAY 15 '58</b>						

WISCONSIN STATE DEPARTMENT OF NATURAL RESOURCES

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME	EDWARD J. KELLY
SEX	MALE
BIRTH DATE	APRIL 10, 1910
MATERIAL TESTED	SKULL
TESTS CONDUCTED	STUDY OF SKULL
TEST RESULTS	DEATH DUE TO ACCIDENT
TESTER'S SIGNATURE	
TESTER'S TITLE	LABORATORY DIRECTOR
TESTER'S ADDRESS	100 N. STATE ST. MADISON, WISCONSIN
TESTER'S PHONE NUMBER	608-267-2111

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5295

## CERTIFICATE OF DEATH

Reg. Dist. No.

05264

1. PLACE OF DEATH a. COUNTY <i>A.A. County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Florida</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millerville (Rural) Janesville</i>		c. LENGTH OF STAY IN 1b <i>1 Month</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Saints Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Clyde</i>	Middle <i></i>	Last <i>Cook</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>17th</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 1st - 1888</i>
9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BARTENDER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>TAVERN</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Abraham Cook</i>		14. MOTHER'S MAIDEN NAME <i>Eichelberger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>317-16-7339</i>	
17. INFORMANT <i>Monnie Edien, Crownsville-Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) <i></i>		(County) <i></i> (State) <i></i>	
21. I certify that I attended the deceased from <i>4-29-58</i> to <i>5-17-58</i> , that I last saw the deceased alive on <i>5-17-58</i> , and that death occurred <i>10P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i></i>	
ACTUAL SIGNATURE <i>DR. JOSEPH LIPSKEY</i>		DATE SIGNED <i>Odenton, Md.</i>	
PHYSICIAN'S NAME (1st & 2nd) <i>DR. JOSEPH LIPSKEY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 21, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Washington</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 21 '58</i>	
ADDRESS <i>Glen Burnie, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Albert Edward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

DEATH CERTIFICATE  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5296

Items 7, 11, 12 File G229 6-3-58 et

05265

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PN3. Page 5 may be retained for your file.

**TO FUNERAL DIRECTOR:** Pages 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deale Beach</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairhaven</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>BETTY</b>	Middle <b>EVA</b>	Last <b>CRAWFORD</b>	4. DATE OF DEATH Month <b>May</b>	Day <b>14</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 16 1898</b>	9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New Britain, Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm Markovich</b>		14. MOTHER'S MAIDEN NAME <b>Eva Karclok</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive decomposition of body</b> DUE TO <b>929.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Presumed drowning</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found lying face down on beach 8' from water (Deale Beach)</b>					
20c. TIME OF INJURY Hour <b>Found 5:50 p.m.</b>		Month, Day, Year <b>5/21 1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Water</b>		20f. (City or town) <b>Anne Arundel Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		DATE SIGNED <b>5/22/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>5/24/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) <b>New Britain Conn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Ulrich, Balt. Md.</b>		ADDRESS		24e. REC'D. BY REGISTRAR DATE <b>May 26 '58</b>		24f. REGISTRAR'S SIGNATURE <b>Albert Ulrich</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5257

## CERTIFICATE OF DEATH

Reg. Dist. No.

05258

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		o. STATE <u>Md</u> b. COUNTY <u>aa</u>	
<u>Annapolis Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
63 a. General Hosp.		<u>1705 Melvin Ave</u>			
3. NAME OF DECEASED (Type or print)		First <u>Virginia</u>	Middle <u>Gaither</u>	Last <u>Currick</u>	4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1958</u>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.
<u>Female</u>		<u>White</u>		<u>1-26-1869</u>	<u>89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>House wife</u>		<u>Home</u>		<u>Maryland</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>Lusby Gaither</u>		<u>Unknown</u>		<u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)				<u>Ms Amos S. Lorenz</u> Address <u>②</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Heart Disease</u> INTERVAL BETWEEN DUE TO <u>420.0</u> ONSET AND DEATH <u>unknown</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Intestinal Hemorrhage</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from <u>5/22</u> , 1958, to <u>5/24</u> , 1958, that I last saw the deceased alive on <u>5/24</u> , 1958, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D. ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-27-58</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Cedar Bluff</u>	
22d. LOCATION (City, town, or county) <u>Annapolis</u>				(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jean M. Layla Sims Annapolis Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Outreach</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5259

## CERTIFICATE OF DEATH

Reg. Dist. No.

05261

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE—(Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>A.A.Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>7 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>30 Cornhill</b>		d. STREET ADDRESS <b>30 Cornhill</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Archibald</b>	Middle <b></b>	Last <b>Coates</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>16</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-1885</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Coates</b>		14. MOTHER'S MAIDEN NAME <b>Mary Matthews</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>R18-12-9498</b>		17. INFORMANT <b>Claudella Coates—30 Cornhill Street</b>		Address <b>Annapolis-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Centrifugal heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic vascular disease grade III</b> DUE TO <b>3 months</b> (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>110 Clay Street</b>		20f. (City or town) (County) (State) <b>Annapolis</b>	
21. I certify that I attended the deceased from <b>May 14, 1958</b> to <b>May 16, 1958</b> , that I last saw the deceased alive on <b>5-16, 1958</b> , and that death occurred at <b>1:PM</b> M.D. from the causes and on the date stated above. ACTUAL SIGNATURE <b>R.L. Richardson</b> ADDRESS (Street, city or town, state) <b>110 Clay Street-Anna, Md.</b> DATE SIGNED <b>110-CLAY ST ANN ARBOR, MI, 5/19/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-19-58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks</b>		ADDRESS <b>Annapolis-Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

81. SHORTLINE—HEALTH AND HUMAN SERVICES CHARTER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5260

## CERTIFICATE OF DEATH

Reg. Dist. No.

05266

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 ANNAPOLEIS</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>			e. STREET ADDRESS <b>734 GLENWOOD STREET</b>					
3. NAME OF DECEASED (Type or print) <b>DAISY MALVINA CRUTCHLEY</b>			4. DATE OF DEATH <b>MAY 20 1958</b>	Month <b>MAY</b>	Day <b>20</b>	Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 5, 1891</b>	9. AGE (In years lost birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Vinton Thomas</b>			14. MOTHER'S MAIDEN NAME <b>Daisy Basil</b>			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Mr. Robert Crutchley-Husband- same as # 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carnia</b> DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Arteriosclerotic nephrosclerosis</b> DUE TO (c) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary insufficiency</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>May 30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 30</b> , 19 <b>58</b> , and that death occurred at <b>12 45 PM</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>John L. Hedeman</b> M.D.						ADDRESS (Street, city or town, state) <b>121 Cathedral</b> Annapolis Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>June 2, 1958.</b>			22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Bluff Cemetery</b>		
22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>						(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>			ADDRESS <b>ANNAPOLEIS, MARYLAND</b>			24a. REC'D BY REGISTRAR DATE <b>JUN 3 1958</b>		
						24b. REGISTRAR'S SIGNATURE <b>Quinn</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of his certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

NAME OF DECEASED		ADDRESS	
JOHN	DOE	1234 FAIRFIELD DR.	BALTIMORE, MD 21204
AGE	65	SEX	M
DEATH DATE	12/15/2023	TIME	10:00 AM
CAUSE OF DEATH	Cardiac Arrest		
DEATH OCCURRED	At Home		
DEATH CERTIFIED	By Doctor of Medicine		
NAME OF DOCTOR	Dr. John Doe, MD		
ADDRESS OF DOCTOR	1234 FAIRFIELD DR., BALTIMORE, MD 21204		
PHONE NUMBER	(410) 555-1234		
DATE ISSUED	12/15/2023		
ISSUED BY	Maryland State Department of Health		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5297

## CERTIFICATE OF DEATH

Reg. Dist. No.

05267

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>	c. LENGTH OF STAY IN 1b <i>29 yrs.</i>	b. COUNTY <i>Anne Arundel</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Race Road</i>	e. STREET ADDRESS <i>Race Road</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John</i>	First <i>J</i>	Middle <i>S.</i>	Last <i>Ree</i>
4. DATE OF DEATH <i>May 12 1958</i>	Month <i>May</i>	Day <i>12</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 1 1896</i>
9. AGE (In years last birthday) yrs. <i>61</i>	10. UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Garage Foreman McNamee of Lancaster</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>George John F. McNamee 820-05-4040</i>	14. MOTHER'S MAIDEN NAME <i>Mary Mullins</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Mrs. Evelyn Leishman, Laurel, Md</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Jessup Maryland</i>	
21. I certify that I attended the deceased from <i>1955</i> , 19, to <i>1958</i> , 19, that I last saw the deceased alive on <i>May 12 1958</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. Wingfield</i>		ADDRESS (Street, city or town, state) <i>DeWitt Randolph, Laurel, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT C. WINGFIELD</i>		DATE SIGNED <i>May 12 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 15, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Lawrence</i>	22d. LOCATION (City, town, or county) (State) <i>Jessup Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Randolph, Laurel, Md</i>		24a. REC'D BY REGISTRAR DATE <i>May 16 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Quesada</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 229 5-23-58 ams

05268

5298

## CERTIFICATE OF DEATH

Reg. Dist. No 27

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meads</b>		c. LENGTH OF STAY IN 1b <b>1 yr 7 mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Dundalk)</b>		d. STREET ADDRESS <b>1925 Rettman Lane</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>		First	Middle	Last	4. DATE OF DEATH <b>DELMERICO</b>	Month <b>MAY</b>	Day <b>6</b>	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>22 May 1905</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>2</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>deceased - unknown</b>		14. MOTHER'S MAIDEN NAME <b>deceased - unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>761941-37458-21538-8853</b>		17. INFORMANT <b>Records - Fort George G Meade, Md</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for Part I and Part II] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b>		DUE TO <b>Postoperative hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Endobronchial biopsy</b>		DUE TO <b>Endobronchial biopsy</b>						
(c) <b>Anaplastic carcinoma of the right upper lobe</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
p. m.								
21. I certify that I attended the deceased from <b>5 May</b> , 19 <b>58</b> , to <b>6 May</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6 May</b> , 19 <b>58</b> , and that death occurred at <b>1315P.M.</b> from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>Gene D. Trettin</b>								
DATE SIGNED <b>6 May 58</b>								
ACTUAL SIGNATURE <b>Gene D. Trettin</b>								
PHYSICIAN'S NAME (Type) <b>GENE D. TRETTIN, MD, U. S. ARMY HOSPITAL, FT GEORGE G. MEADE, MARYLAND</b>								
22a. BURIAL/CREMATION/ REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5/9/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Edwards' Funeral Home</b>		22d. LOCATION (City, town, or county) <b>Hobbs Ferry, New York</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carl B. Woherton Funeral Home, Inc.</b>		ADDRESS <b>6306 - Belair Rd - Baltimore - 6, Md.</b>		24a. REC'D BY REGISTRAR <b>May 58</b>		24b. REGISTRAR'S SIGNATURE <b>Clarence D. Lainster, CMO</b>		

81. ЗАДАЧА 7. Решите уравнение  $\frac{1}{x-1} + \frac{1}{x+1} = \frac{2}{x^2-1}$ .

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05269

5299

## CERTIFICATE OF DEATH

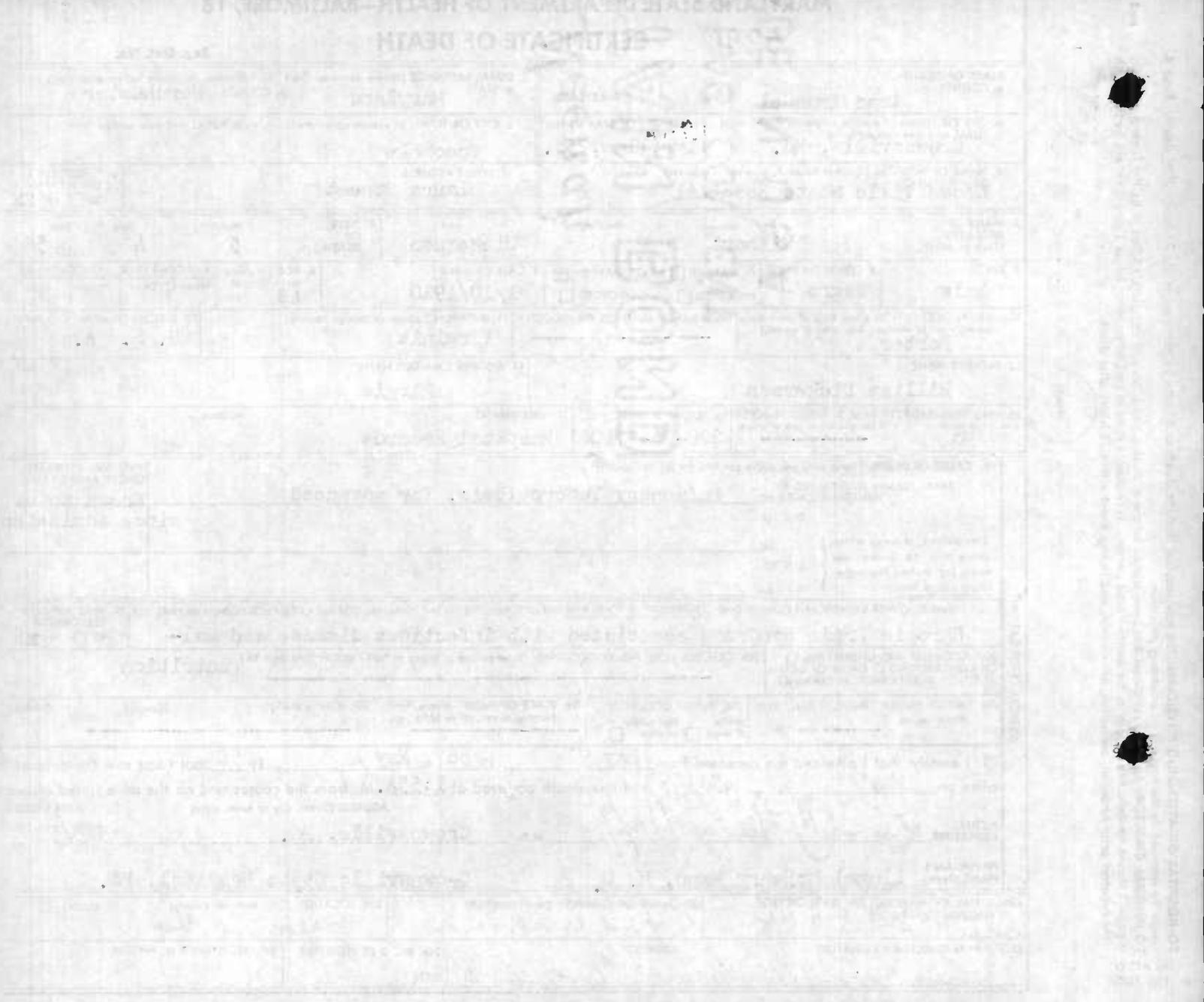
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville, Md.</b>		c. LENGTH OF STAY IN lb <b>lyr, 11mo, 25d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>		23rd, 1958			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>		e. STREET ADDRESS <b>Laura Street</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Wilbert</b>		First	Middle	Last	4. DATE OF DEATH <b>Dickerson</b>	Month <b>5</b>	Day <b>4</b>	Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1/10/1910</b>	9. AGE (In years last birthday) <b>48</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William Dickerson</b>					14. MOTHER'S MAIDEN NAME <b>Margie</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-26-7710</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, far advanced</b> DUE TO 002X Known to us since admission Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome associated with infectious disease and mal-nutrition</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>nutrition</b>							
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ 19 p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Crownsville, Md.</b>		(County)	(State)
21. I certify that I attended the deceased from <b>May 9</b> , 19 56, to <b>May 4</b> , 19 58, that I last saw the deceased alive on <b>May 4</b> , 19 58, and that death occurred at <b>1:55A.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Lionel McHenry Mapp, M.D.</i>		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/5/58</b>							
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		Crownsville State Hospital, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>5-7-'58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>C. Fred. Wm. Schon</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Keest 108 Wash. St. Annapolis, Md.</i>		ADDRESS <i>William Keest 108 Wash. St. Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <b>MAY 9 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Deb. Smith</i>			

81 (CONT'D) - HEAVY TO MEDIUM STATE OF DIAVOL

HEAVY TO MEDIUM STATE OF DIAVOL

APR 24 1948



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G229, 5/26/58 f.c.v

05270

5261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Anne Arundel MARYLAND</i>		<i>Maryland A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>		e. STREET ADDRESS <i>45 C. Ck. Terrace</i>	
3. NAME OF DECEASED (Type or print)		First <i>Martha</i>	Middle <i>Diggs</i>
4. DATE OF DEATH		Month <i>5</i>	Day <i>12</i>
5. COLOR OR RACE <i>Female Col.</i>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>6-15-1874</i>
8. AGE (In years lost birthday) <i>83 84 yrs.</i>		9. IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dremery, Md.</i>	11. MIRTHPLACE (State or foreign country) <i>U.S.A.</i>
13. FATHER'S NAME <i>Joseph Owens</i>		14. MOTHER'S MAIDEN NAME <i>Annie Owens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>James Gant-Annapolis, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>80 hrs.</i>	
20a. ACCIDENT WAS UNDERRYLING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ June, 1950 to _____ 5-12 1958, that I last saw the deceased alive on _____ 5-12 1958, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Faye W. Allen</i>		PHYSICIAN'S NAME (Type) <i>Faye W. Allen</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-15-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		24a. ADDRESS ADDRESS	24c. REGISTRAR'S SIGNATURE <i>Arleene</i>
		24b. REC'D BY REGISTRAR <i>MAY 16 '58</i>	

STATE OF KANSAS

CERTIFICATE OF MAIL

REGISTRATION NO.

MAILING ADDRESS

RECEIVING ADDRESS

NAME OF SENDER

NAME OF RECIPIENT

NAME OF CARRIER

NAME OF ADDRESSEE

NAME OF SENDER

NAME OF RECIPIENT

NAME OF ADDRESSEE

NAME OF SENDER

NAME OF RECIPIENT

NAME OF ADDRESSEE

NAME OF SENDER

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05271

## CERTIFICATE OF DEATH

Reg. Dist. No.

530

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b>		d. STREET ADDRESS <b>302 C Street, N.E.</b>	
d. NAME OF HOSPITAL OR INSTITUTION <b>District Training School Children's Center, Laurel, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Samuel</b>	Middle <b>Dozier, Jr.</b>	Last	4. DATE OF DEATH	Month <b>May</b>	Day <b>4</b>	Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>2/16/57</b>	9. AGE (In years last birthday) <b>1 yrs.</b>	IF UNDER 1 YEAR Months <b>--</b>	IF UNDER 24 HRS. Days <b>--</b>	Hours <b>--</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Dozier Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Leedora Moss</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>	16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT <b>Social Service, Children's Center, Laurel, Md.</b>	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b>							
INTERVAL BETWEEN ONSET AND DEATH FROM BIRTH							
752X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>--</b> DUE TO (c) <b>--</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>--</b>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>--</b> 19 p. m. <b>--</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>	20f. (City or town) <b>--</b>	(County) <b>--</b>	(State) <b>--</b>	
21. I certify that I attended the deceased from <b>11/4/57</b> , 19, to <b>5/4/58</b> , 19, that I last saw the deceased alive on <b>5/4/58</b> , 19, and that death occurred at <b>1:18 p.m.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b>							
DATE SIGNED							
ACTUAL SIGNATURE <i>James E. Boyland</i>	M.D.						
PHYSICIAN'S NAME (Type) <b>James E. Boyland, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-6-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>DTS Cemetery</b>	22d. LOCATION (City, town, or county) <b>Laurel, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Young Jr. D.T.S. Laurel Md</i>	ADDRESS <b>---</b>	24a. REC'D BY REGISTRAR DATE <b>MAY 8 '58</b>	24b. REGISTRAR'S SIGNATURE <i>W.L. Smith</i>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05272

5301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Mills</i>	c. LENGTH OF STAY IN 1b <i>10 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	d. STREET ADDRESS <i>1916 Spa Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Myrtle Gladys Ennis</i>	First <i>M</i>	Middle <i>Y</i>	Last <i>Ennis</i>	4. DATE OF DEATH Month <i>May</i> Day <i>21</i> Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cook</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>12-23-1932</i>	9. AGE (In years from birthday) <i>25 yrs.</i>	IF UNDER 1YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Little Campus Inn</i>	11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Richard Ennis Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Martha Smith</i>	Address <i>Annapolis, Md.</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213-28-4458</i>	17. INFORMANT <i>Sylvia Ennis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Deceased</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>						
20c. TIME OF INJURY Month, Day, Year Hour <i>May m. 3/21/58 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>E. Linhardt</i> EXAMINER'S NAME (Type) <i>E. Linhardt</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-25-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William George Anna, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>Reed couch</i>	24b. REGISTRAR'S SIGNATURE			
VS. A15ME SM 2/57		DATE <i>MAY 26 '58</i>				

01. ПРОДАЖА - НАСАДОК И МАСЛО ОСНОВНОЕ  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05273

5262

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>A.A.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parole A.A Co Md</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. James General Hospital</i>		d. STREET ADDRESS <i>Shady Oaks</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>P.</i>	Last <i>Faudree</i>	4. DATE OF DEATH <i>5-2</i>	Month <i>5</i>	Day <i>2</i>	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 12<sup>th</sup> 1891</i>	9. AGE (In years lost birthday) <i>66 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handy Man Auto. Garage</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Garage</i>		11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Luther Faudree</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lula A. Faudree Parole A.A Co Md</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>570.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. {		DUE TO (b) early peritonitis		superior mesenteric artery thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>30 hours</i>		
DUE TO (c) with infarction of most of small bowel								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>paralytic ileus</i>						
20c. TIME OF INJURY Hour a.m. p.m.	Month <i>May</i>	Day <i>19</i>	Year <i>58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Glen Burnie Md</i>	(County) <i>Glen Burnie Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>4-1-52</i> to <i>5-2-58</i> , that I last saw the deceased alive on <i>5-2-58</i> , and that death occurred at <i>Glen Burnie Md</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>45 FRANKLIN ST</i> DATE SIGNED <i>5-2-58</i>								
ACTUAL SIGNATURE <i>Solomon Rosello M.D.</i>	PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>		22c. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-5-58</i>	22d. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Memorial</i>	22d. LOCATION (City, town, or county) <i>Glen Burnie Md</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>		ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>D. Smith</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 FRONTAGE ROAD, TELMASEB, BULGARIA 7000

2107

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5263

## CERTIFICATE OF DEATH

Reg. Dist. No.

05274

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>35 Jefferson Place</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				d. STREET ADDRESS <i>35 Jefferson Place</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Myra Henrietta Frank</i>		First	Middle	Last	4. DATE OF DEATH <i>May 16 1958</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Sept. 7 1884</i>	9. AGE (In years, last birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Ernest C. Gauss</i>		14. MOTHER'S MAIDEN NAME <i>Alvarettta Green</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Reginal Chambers #2</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>DIABETES MELLITUS</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>									
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County)	(State)	
21. I certify that I attended the deceased from <i>Jan 1, 1958</i> , to <i>16 May 1958</i> , that I last saw the deceased alive on <i>16 May 1958</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Beck M.D.</i> PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-18-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Bluff</i>		22d. LOCATION (City, town, or county) <i>Annapolis Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor &amp; Sons Annapolis Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAY 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John H. Taylor</i>			

## CERTIFICATE OF DEATH

252

Date  
1972

Place of Death

Cause of Death

Time of Death

Name of Hospital

Name of Doctor

Name of Mortician

Name of Coroner

Name of Sheriff

Name of Clerk

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5302

## CERTIFICATE OF DEATH

Reg. Dist. No.

05275

TO HOSPITAL OR ATTENDANT  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MILLERSVILLE</i>		c. LENGTH OF STAY IN 1b <i>7 mos.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>A.A. Co.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>S'ANNS NURSING HOME</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FERNDALE</i>		f. STREET ADDRESS <i>104 BALTIMORE, Md.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>ERNEST</i>	Last <i>FREEZE</i>	4. DATE OF DEATH Month <i>MAY</i>	Day <i>19</i>	Year <i>1958</i>			
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT. 24, 1883</i>	9. AGE (In years lost birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RAILroad Dispatcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>RAILROAD</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>					
13. FATHER'S NAME <i>George Freeze</i>		14. MOTHER'S MAIDEN NAME <i>Morriet Gough</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>JEAN WILLIAMS</i>		Address <i>MILLERSVILLE</i>			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>		DUE TO <i>442X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>several days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cardio Vascula</i>		(c) <i>Paval disease 1 year</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>Loudon Park</i>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>4-14-58</i> to <i>5-19-58</i> , that I last saw the deceased alive on <i>4-17-58</i> , and that death occurred <i>5-19-58</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>		DATE SIGNED	
ACTUAL SIGNATURE <i>Joseph Lipskey</i>									
PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKY</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 22, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Lipskey</i>		ADDRESS <i>Hopping &amp; KIRKLEY, Glen Burnie</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albert Edwards</i>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323

## CERTIFICATE OF DEATH

Reg. Dist. No. 05278

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b ? ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Glen Burnie, (Glen Gardens)</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>503 Kent Road</i>		d. STREET ADDRESS <i>503 Kent Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>Cross</i>	Last <i>Gardner</i>	4. DATE OF DEATH <i>May 4 1958</i>	Month <i>May</i>	Day <i>4</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Apr. 7-1885</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attendant(Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Barrows Garage</i>		11. BIRTHPLACE (State or foreign country) <i>Sherman, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George T. Gardner</i>		14. MOTHER'S MAIDEN NAME <i>Minerva Disney</i>		Address <i>Same as above</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-14-5255</i>		17. INFORMANT <i>Mrs. Dorothy Hayes</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hours</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Arteriosclerotic Heart Disease</i> DUE TO (c)						3 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m. 19	Month 19	Day at work	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6 Lombard St</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Oct 1946</i> to <i>May 4 1958</i> , that I last saw the deceased alive on <i>April 15 1958</i> , and that death occurred at <i>1:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Edward G. Bennett</i>		DATE SIGNED <i>5-4-58</i>			
ACTUAL SIGNATURE <i>Edward G. Bennett</i>	PHYSICIAN'S NAME (Type) <i>Edward G. Bennett</i>	M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 7 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cemetery</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie, Maryland</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Livingston</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>MAY 8 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Albert E. Deacon</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5304

## CERTIFICATE OF DEATH

Item 1 Film G229 5-19-58 et

05277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Pasadena) Pinchurst on the Bay</b>				c. LENGTH OF STAY IN 1b <b>Pasadena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>CLARENCE</b>	Middle <b>A.</b>	Lost	4. DATE OF DEATH <b>May</b>	Month	Doy <b>11, 19 58</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 15, 1875</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months <b>83</b>	IF UNDER 24 HRS. Days <b>0</b>	Year Hours Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Train Dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>- Rufus Gosnell</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Burton -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Jeanette B. Gosnell - Pasadena, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic cardiovascular disease with coronary insufficiency</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>generalized osteoarthritis</b>				WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>White Nat while at work</b>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Pasadena</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>May 12, 1958</b> to <b>May 11, 1958</b> that I last saw the deceased alive on <b>May 11, 1958</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pasadena, Maryland</b> DATE SIGNED <b>May 13, 1958</b>							
ACTUAL SIGNATURE <b>R. M. McLaughlin</b>		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Sickner &amp; Sons - Baltimore</b>		ADDRESS <b>17th and West Street</b>					
		24a. REC'D BY REGISTRAR DATE <b>MAY 13 '58</b>					
		24b. REGISTRAR'S SIGNATURE <b>W. E. Smith</b>					

印第安纳州立大学图书馆

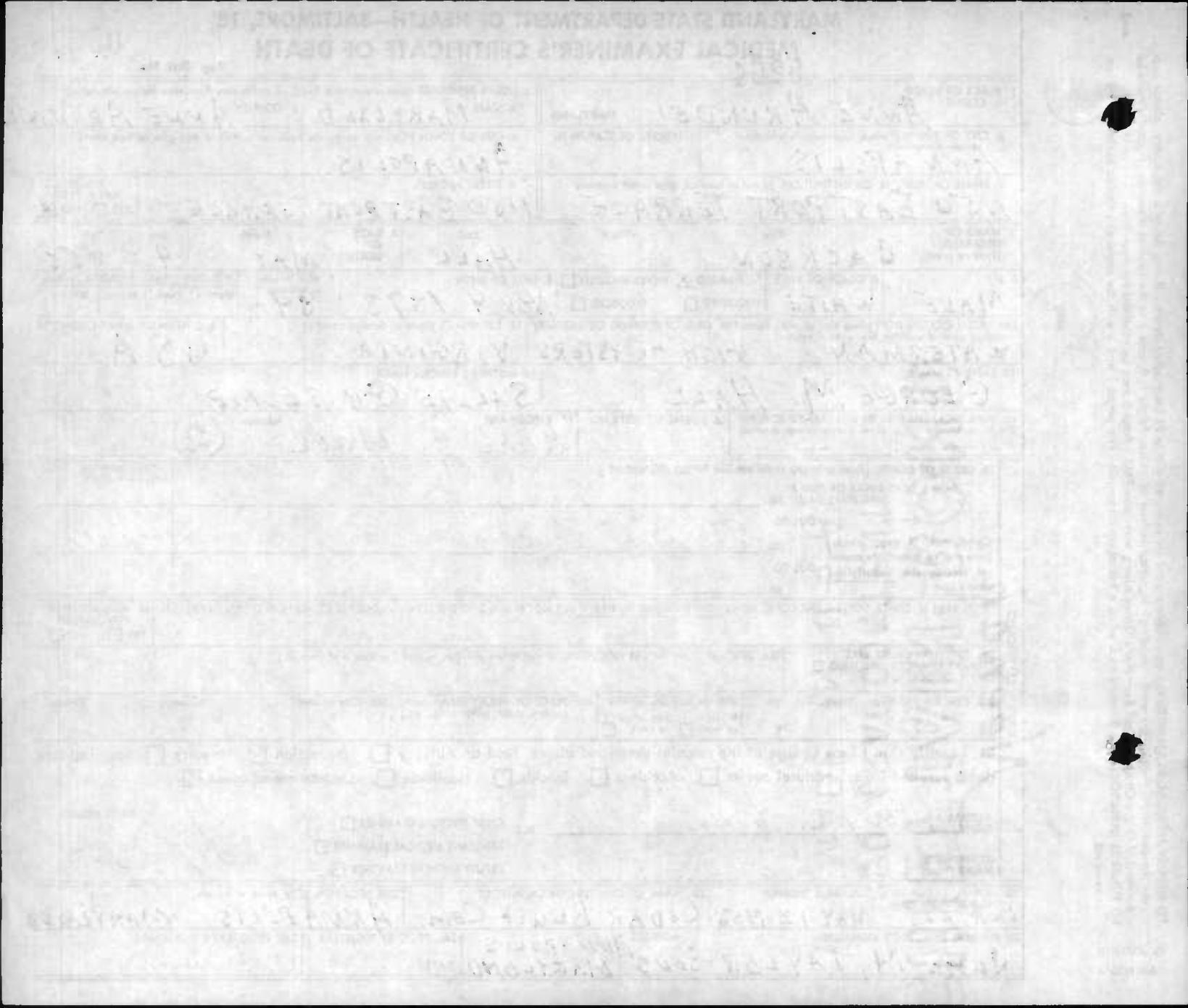
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05278

Reg. Dist. No.

1		5264										1	
1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
		ANNAPOLIS			c. LENGTH OF STAY IN lb				a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
		1150 EAST PORT TERRACE			ANNAPOLIS 10							1150 EASTPORT TERRACE	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year				
MALE		WHITE	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Nov 9 1873		84	9	1958	IF UNDER 1YEAR IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years Leave blank if infant)					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
WATERMAN		FISH - OYSTERS		VIRGINIA		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
GEORGE M. HALL		SALLIE GRISCOMB											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
—		—		Earl J. Hall		(2)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO <u>Sudden Death Disease</u> INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diseases</u> DUE TO <u>Sudden</u> (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>E. Linhardt</i>		DATE SIGNED <i>May 9/58</i>											
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>MAY 12 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR BLUFF CEM.</i>		22d. LOCATION (City, town, or county) <i>ANNAPOLIS MARYLAND</i>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>JOHN M. TAYLOR &amp; SONS</i>		ADDRESS <i>ANNAPOLIS MARYLAND</i>		24a. REC'D BY REGISTRAR <i>MAY 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. Seach</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial or removal.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5305

## CERTIFICATE OF DEATH

Reg. Dist. No.

05279

1. PLACE OF DEATH o. COUNTY <i>4A</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i>		b. COUNTY <i>A.A.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>P.T. Pleasant</i>		c. LENGTH OF STAY IN 1b <i>Yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>P.T. Pleasant</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>P.T. Pleasant Beach</i>		d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>104</i>	Middle <i>H</i>	Last <i>Henryman</i>	4. DATE OF DEATH <i>5-22-1958</i>	Month <i>5</i>	Day <i>22</i>	Year <i>19 58</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept 4-1901</i>	9. AGE (In years last birthday) <i>56 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Henry Sherman</i>		14. MOTHER'S MAIDEN NAME <i>OSSIE Townsley</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Family</i>			Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach with metastases all throughout b. &amp; l. tract</i>		DUE TO <i>151X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>metastases all throughout b. &amp; l. tract</i>		DUE TO <i>151X</i>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5 Fairview St E</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>M.D.</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>11/2/57</i> , 19 <i>57</i> , to <i>5/22/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/22/58</i> , 19 <i>58</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Louis H. Faubert M.D.</i>		ADDRESS (Street, city or town, state) <i>5 Fairview St E, Baltimore, Md.</i>		DATE SIGNED <i>7/2/58</i>				
PHYSICIAN'S NAME (Type) <i>LUSTAVI. H. FAUBERT M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		22b. DATE THEREOF <i>5-26-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Glen Haven Am.</i>	22d. LOCATION (City, town, or county) <i>Glen Burnie, Md.</i>	(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCullough Funeral Home</i>		ADDRESS <i>130 E Fort Ave.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>			

THE STATE OF ALABAMA  
DEPARTMENT OF HUMAN RESOURCES

CERTIFICATE OF DEATH

02-0

DEATH

REGISTRATION

NUMBER

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

EMAIL

SSN

MR/MR

MS/MS

DEATH

REGISTRATION

NUMBER

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

EMAIL

SSN

MR/MR

MS/MS

DEATH

REGISTRATION

NUMBER

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

EMAIL

SSN

MR/MR

MS/MS

FOR STATE  
HEALTH DEPT.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5336

05280

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL <u>Altobone Beach, Glen Burnie</u> )		c. LENGTH OF STAY IN 1b <u>1½ hour.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		d. STREET ADDRESS <u>910 Potapsco Avenue</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Big Burley Cove, off Stoney Creek</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Ronald Michael Haslego</u>		First	Middle	Lost	4. DATE OF DEATH <u>May 18th.</u>	Month	Day	Year <u>19 58</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/18/41</u>	9. AGE (In years last birthday) <u>16</u>	10. IF UNDER 1 YEAR Months <u> </u>	11. IF UNDER 24 HRS. Days <u> </u>	12. IF UNDER 24 HRS. Hours <u> </u>	13. IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hazleton, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Michael Haslego</u>		14. MOTHER'S MAIDEN NAME <u>Celia Kilusky</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Michael Haslego, (father)</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning .</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Was swimming in 15 feet of water and suddenly went under the water.</u>						
20c. TIME OF INJURY Hour <u>4 p.m.</u>		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Big Burley Cove Altobone Beach, Glen Burnie, A.A.</u>		(City or town) <u> </u>		(County) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED <u>5/18/58</u>						
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>5/22/58</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Holy Cross</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes - 130 E. Fort Avenue</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>Quesenbach</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		
VS. A15ME SM 2/57		DATE <u>MAY 21 '58</u>						

20

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05281

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		5307 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>F.F.F.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brown Woods</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brown Woods</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brown Woods Hospital</i>		e. STREET ADDRESS <i>RFD (4) Box 28A</i>		f. DATE OF DEATH Month <i>MAY</i>		Year <i>1958</i>	
3. NAME OF DECEASED (Type or print) <i>VIOLA EVELYN Henson</i>		First Middle Last		g. DATE OF BIRTH Month <i>June 17, 1930</i>		h. AGE (In years last birthday) yrs. <i>27</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>CW</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		i. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <i> </i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Brown Woods AAC, NC (S.F.)</i>		12. CITIZEN OF WHAT COUNTRY? <i>Brown Woods AAC, NC (S.F.)</i>	
13. FATHER'S NAME <i>Dennis Harold</i>		14. MOTHER'S MAIDEN NAME <i>Lora Stanbury</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-30-5252</i>	
17. INFORMANT IMMEDIATE CAUSE (a) <i>191X</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Cervix</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) (c)		DUE TO					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i> </i>		20f. (City or town) (County) (State) <i> </i>					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.L. Richardson</i>		ADDRESS (Street, city or town, state) <i>110-Clay St. F.F.F. Baltimore, Md. 21202</i>		DATE SIGNED <i>May 18, 1958</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-21-1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Broadneck</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore A.A.C.O. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reesett #108 Wash. St. Anna, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>May 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Outstanding</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF TRANSPORTATION - STATE OF ILLINOIS

STATE OF ILLINOIS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5265

## CERTIFICATE OF DEATH

Reg. Dist. No.

05282

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1963 West St.</i>		d. STREET ADDRESS <i>1963 West Street.</i>	
3. NAME OF DECEASED (Type or print) <i>Lovelace</i>		First <i>C.</i>	Middle <i>Herrndon</i>
4. DATE OF DEATH Month <i>5</i>		Day <i>22</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-28-1874</i>
9. AGE (In years last birthday) <i>84 yrs.</i>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Isabella Gouch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>James Herrndon 1963 West St.</i>	
17. INFORMANT <i>James Herrndon 1963 West St.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>434.1</i> DUE TO <i>Congestive Cardiac Failure</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Annapolis</i> (County) <i>Anne Arundel Co.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>1-12-387</i> to <i>5-21-58</i> , 19, that I last saw the deceased alive on <i>5-20-58</i> , 19, and that death occurred at <i>1426</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>6 L Cathedral St Annapolis, Md.</i> DATE SIGNED <i>5-23-58</i>	
ACTUAL SIGNATURE <i>A. T. Allen</i>		PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-25-58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Brewer Hall</i>		22d. LOCATION (City, town, or county) <i>Annapolis Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Beesett</i>		ADDRESS <i>108 Washington Annapolis Md.</i>	
24a. REC'D BY REGISTRAR <i>MAY 26 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Bob Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be torn off with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNITED STATES GOVERNMENT - DEPARTMENT OF HUMAN SERVICES

THE SECRETARY OF HUMAN SERVICES

THE DEPARTMENT OF HUMAN SERVICES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>a a</i> <i>MARYLAND</i>		a. STATE <i>Md</i>	b. COUNTY <i>a a</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Davidsonville</i>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <i>19.7 D.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>a a General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frederick</i>		First <i>James</i>	Middle <i>Holland</i>
		Last <i>James</i>	4. DATE OF DEATH <i>5-5-1958</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Apr 20-1883</i>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>75 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Get City Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Foreman</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Holland</i>		14. MOTHER'S MAIDEN NAME <i>Laura Collins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Nicholas Bottner</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cpd Prochlorperazine Skg</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Leadcure Reba Tabular Rx. Sudex</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Struck by Auto</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>PM 5/5/58</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <i>Auto</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Whack</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Whack</i>		DATE SIGNED <i>5/6/58</i>	
22a. CERIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-8-58</i>	22c. NAME OF CEMETERY OR CREMATORIY <i>St Marys</i>
22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Box 200 Annapolis MD</i>	24a. REC'D BY REGISTRAR DATE MAY 8 '58
		24b. REGISTRAR'S SIGNATURE <i>W.L. Evans</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MISSOURI STATE POLICE - DIVISION OF INVESTIGATION  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED PERSON'S NAME  
Date of Birth

DECEASED PERSON'S ADDRESS

SEX  
Age

Height  
Weight  
Color of Hair

Place of Death

Time of Death  
Cause of Death

A

Medical History  
Physical Condition  
External Examination  
Internal Examination  
Post Mortem Findings  
Autopsy Findings  
Other Findings  
Conclusion  
Signature

External  
 Internal  
 Autopsy  
 Other

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5308

## **CERTIFICATE OF DEATH**

05284

**Reg. Dist. No**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>1 yr. 22 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>			e. STREET ADDRESS <b>35 Dean Street</b>			
3. NAME OF DECEASED (Type or print)		First <b>Nicholas</b>	Middle	Last <b>Hopkins</b>	4. DATE OF DEATH <b>Month 5 Day 20 Year 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6/9/04</b>	9. AGE (In years lost birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>Oliver Hopkins</b>			14. MOTHER'S MAIDEN NAME <b>Celia Parker</b>			Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>023X</b>						
DUE TO (b) <b>Congestive Heart failure</b>						
DUE TO (c) <b>Syphilitic Cardiovascular Disease</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____
21. I certify that I attended the deceased from <b>5/8</b> , 19 <b>57</b> , to <b>5/20/58</b> , 19_____, that I last saw the deceased alive on <b>5/20</b> , 19 <b>58</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED						
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		Crownsville State Hospital, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-24-1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Brewer Hill</b>	22d. LOCATION (City, town, or county) <b>Annapolis Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Seese, D</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 23 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Asst. mil</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
1SM 10/57

BY JOURNALIST OF THE ATARIO STATE GRAMPA

ITABO TO STACITRAZ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5309

## CERTIFICATE OF DEATH

Reg. Dist. No.

05285

1. PLACE OF DEATH o. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		o. STATE Maryland b. COUNTY Anne Arundel	
Holly Hill Harbor, Edgewater 1 year				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		X Holly Hill Harbor, Edgewater	
Rt. 1, Box 216-B, Holly Hill Harbor		Rt. 1, Box 216 B		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Raymond Edward	Middle	Last Hunt	4. DATE OF DEATH
5. SEX M		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Captain of Fire Dept.				Washington, D. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward Lee Hunt		Rosa Foust		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Annie Hunt (Wife) Address Rt. 1, Box 216B Edgewater, Maryland	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/4, 1957, to 5/3, 1958, that I last saw the deceased alive on May 3rd, 1958, and that death occurred at 3:30 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		M.D. Rt. 1, Box 277-M		5/3/58	
PHYSICIAN'S NAME (Type)		SYLVIA M. LIM, M.D.		Edgewater, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial May 6-58				22d. LOCATION (City, town, or county) Washington D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Simmons Bros 1661-9th Hope Rd & E		DATE MAY 6 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then, the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17. PROMITAS-STATIUS. EQUITATIO STATIOMANIA

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Items 7 & 9, Film G231, 7/11/58 for  
**5310 CERTIFICATE OF DEATH**

Reg. Dist. No. **06428**

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CROWNSVILLE STATE HOSPITAL</b>		e. STREET ADDRESS <b>308 PULASKI STREET</b>			
3. NAME OF DECEASED (Type or print) <b>JOHNSON</b>		First <b>STANLEY</b>	Middle Last		
4. DATE OF DEATH <b>MAY 30 1958</b>	Month Day Year				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>JULY 1st 1884</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	17. INFORMANT <b>CROWNSVILLE STATE HOSPITAL</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151x Carcinoma of The Stomach</b>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO WITH Metastases to the Liver</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Syphilis Generalized and Cerebral Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>12/18</b> , 19 <b>57</b> , to <b>5/30/</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/29/</b> , 19 <b>58</b> , and that death occurred at <b>11:40 pm</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Ronald McHenry Mapp.</b>	M.D.	ADDRESS (Street, city or town, state) <b>Crownsville State Hospital</b> DATE SIGNED <b>5-30-58</b>			
PHYSICIAN'S NAME (Type) <b>Ronald McHenry Mapp, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 6-7-58</b>	22b. DATE THEREOF <b>7/11/58</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>	(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stanley G. Cease</b>	23b. ADDRESS <b>3729 Carroll St</b>	24a. REC'D BY REGISTRAR <b>John J. Arthur</b>	24b. REGISTRAR'S SIGNATURE <b>John J. Arthur</b>	DATE JUN 12 '58	

DEPARTMENT OF STATE  
CENSUS OF THE STATE OF NEW YORK

RECEIVED FROM THE CENSUS BUREAU  
MAY 10, 1900

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05286

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cornold</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cornold</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cornold P.O.</i>	d. STREET ADDRESS <i>Cornold P.O.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Alice</i> Middle <i>Anita</i> Last <i>Kelley</i>	4. DATE OF DEATH Month <i>5</i> Day <i>8</i> Year <i>1958</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 11th 1906</i>	9. AGE (In years last birthday) yrs. <i>51</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Penn.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Stephen Kelley</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Bronson</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>- - -</i>	17. INFORMANT <i>Mr Guy H. Kirby</i> Address <i>②</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150X</i> DUE TO <i>gen carcinoma of rectum</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>carcinoma of esophagus.</i> DUE TO (c)				10 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel Co.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan.</i> , 19 <i>58</i> , to <i>May 8</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 7</i> , 19 <i>58</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>Amos James Berr.</i>							
ACTUAL SIGNATURE <i>S. Bronson</i>	PHYSICIAN'S NAME (Type) <i>S. Boassuck</i>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-11-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor Sons Annapolis Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>May 12 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Deuch</i>			

## CERTIFICATE OF DEATH

Date:

Place of Death:

Name of Physician:

Name of Hospital:

Name of Coroner:

Name of Pathologist:

Name of Mortician:

Name of Cemetery:

Name of Funeral Home:

Name of Attorney:

Name of Probate Court:

Name of Sheriff:

Name of Clerk:

Signature:

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05287

## 5267 CERTIFICATE OF DEATH

Item 9, Film G229, 5/16/58 fcy

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	Anne Arundel	MARYLAND	STATE
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN	Annapolis, Md.	2 yrs	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Convalescent Homewood Rest Home	STREET ADDRESS	College Park 1614-2 (If rural give location) Calvert Rd -
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
(First) DELLA		(Middle) MAY (Last) KILGOUR	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	white	Widowed	May 15, 1897
9. AGE last birthday	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
80 yrs.	80		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		own home	North Carolina
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Patrick Cronartie		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		—	
17. INFORMANT & ADDRESS		INTERVAL BETWEEN ONSET AND DEATH	
Nellie Earle College Park Md		4 hours	
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.0</i> IMMEDIATE CAUSE (A) <i>PUL MONARY HEMORRHAGE</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>ARTERIOSCLEROTIC HEART DISEASE</i> 10 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 16, 1958</i> , to <i>6 May</i> , 1958, that I last saw the deceased alive on <i>6 May</i> , 1958, and that death occurred at <i>home</i> , M, from the causes and on the date stated above. SIGNATURE <i>Edward S. Beck</i> M.D. ADDRESS (Street, city, town, state) <i>41 Southgate Anne Arundel, Md</i> DATE SIGNED <i>5/18/58</i>			
VS A15C 1-5 10W		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	
DATE THEREOF <i>5/8/58</i>		NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i>	
24. REC'D BY REGISTRAR <i>MAY 12 '58</i>		REGISTRAR'S SIGNATURE <i>Albert E. ...</i>	
DATE <i>5/8/58</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>F. Busch's Sons Hyattsville Md</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05288

1. PLACE OF DEATH a. COUNTY <i>A.A.C.O.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GLENBURNIE</i>		c. LENGTH OF STAY IN lb <i>6 Mo.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3 BINKNEY RD.</i>		e. STREET ADDRESS <i>3 BINKNEY RD</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>EDWARD</i>		First <i>F.</i>	Middle <i>KIRGAN</i>
4. DATE OF DEATH <i>MAY 3, 1958</i>		Last <i>76</i>	Month Day Year
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 14, 1881</i>
9. AGE (In years last birthday) <i>76 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED TOOL MAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>E.L. KIRGAN CO., OHIO</i>	
11. BIRTHPLACE (State or foreign country) <i>OHIO</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>LEROY KIRGAN</i>		14. MOTHER'S MAIDEN NAME <i>LIESETTE SCHMITZ</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>298-10-9614</i>	
17. INFORMANT <i>MRS. NAOMI A. KIRGAN</i>		Address <i>3 BINKNEY RD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>161X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <i>(b)</i>		1 year	
DUE TO <i>(c)</i>		19. Adenocarcinoma of Larynx & Carcinomatosis 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Mitocardia Insufficiency cold Posterior Infarction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>113 7th Ave.</i>		20f. (City or town) (County) (State) <i>BALTO. MD.</i>	
21. I certify that I attended the deceased from <i>3/14</i> , 19 <i>58</i> , to <i>5/3</i> , 19 <i>58</i> that I last saw the deceased alive on <i>3/14</i> , 19 <i>58</i> , and that death occurred at <i>8:00 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>113 7th Ave.</i>			
ACTUAL SIGNATURE <i>Leopold H. Flay M.D.</i>		DATE SIGNED <i>5/3/58</i>	
PHYSICIAN'S NAME (Type) <i>Leopold H. Flay M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>5/6/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL DIRECTORS <i>LOUDON PARK</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
22e. FUNERAL DIRECTOR'S SIGNATURE <i>WTZEE FUNERAL DIRECTORS</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 6 '58</i>	
ADDRESS <i>4101 EDMONDSON AVE.</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leouch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05289

## CERTIFICATE OF DEATH

Reg. Dist. No.

5313

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a.a.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b 3 Hr 50 Min X	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Patrick	Middle Lee	Last Kirk
4. DATE OF DEATH	Month May	Day 23	Year 19 58
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 23, 1958
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Father's name unknown		14. MOTHER'S MAIDEN NAME Clarice Kirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Alfred L. Kirk Address Qtrs 2352 C Ft George G. Meade, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  776 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO Prematurity (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 58, to _____, 19 58, that I last saw the deceased alive on _____, 19 58, and that death occurred at 2:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE F.W. Lafferty M.D.			
PHYSICIAN'S NAME (Type) Frederick W. Lafferty, Capt, MC.			
22a. BURIAL / CREMATION, REMOVAL (Specify) 5/27/58		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL Balto. National	
22d. LOCATION (City, town, or county) Balto. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Walmer Funeral Home Inc		ADDRESS	
		24a. REC'D BY REGISTRAR DATE MAY 29 1958	
		24b. REGISTRAR'S SIGNATURE R. L. Lafferty	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**5268**

**05290**

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		<b>5268</b>										2																	
M		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday yrs.)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
		a. COUNTY		a. STATE				b. COUNTY				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		May 30 <sup>a</sup> , 1892		65		At Home		Montgomery, Md.	
I		First		Middle		Last		Month		Day		Year																	
		Madge		A		Leake		5		—		5		—															
D		10a.		10b.		11.		12.		13.		14.		15.		16.		17.		18.		19.		20.		21.			
		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (State or foreign country)		CITIZEN OF WHAT COUNTRY?		FATHER'S NAME		MOTHER'S MAIDEN NAME		ADDRESS		WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		SOCIAL SECURITY NO.		INFORMANT		CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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		Housewife		At Home		Montgomery, Md.		U.S.A.		CHARLES ARMSTRONG		LILLIE JORDAN		Defense Highway		No		No		No		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		434.4		Diseases		Diseases	
E		10a.		10b.		11.		12.		13.		14.		15.		16.		17.		18.		19.		20.		21.		22.	
		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (State or foreign country)		CITIZEN OF WHAT COUNTRY?		FATHER'S NAME		MOTHER'S MAIDEN NAME		ADDRESS		WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		SOCIAL SECURITY NO.		INFORMANT		CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH		EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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		Housewife		At Home		Montgomery, Md.		U.S.A.		CHARLES ARMSTRONG		LILLIE JORDAN		Defense Highway		No		No		No		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		434.4		Diseases		Diseases	
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		Housewife		At Home		Montgomery, Md.		U.S.A.		CHARLES ARMSTRONG		LILLIE JORDAN		Defense Highway		No		No		No		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		434.4		Diseases		Diseases	
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		Housewife		At Home		Montgomery, Md.		U.S.A.		CHARLES ARMSTRONG		LILLIE JORDAN		Defense Highway		No		No		No		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		434.4		Diseases		Diseases	
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		Housewife		At Home		Montgomery, Md.		U.S.A.		CHARLES ARMSTRONG		LILLIE JORDAN		Defense Highway		No		No		No		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		434.4		Diseases		Diseases	
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		Housewife		At Home		Montgomery, Md.		U.S.A.		CHARLES ARMSTRONG		LILLIE JORDAN		Defense Highway		No		No		No		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		434.4		Diseases		Diseases	
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		USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY																									

WILCAT SKUNKS CERTIFICATE OF DATA



STATE OF KANSAS

□ State of Kansas □ State of Missouri □ State of Nebraska □ State of Oklahoma □ State of Wyoming

□ Missouri

□ Nebraska

□ Oklahoma

□ Wyoming

□ Kansas

□ Missouri

□ Nebraska

□ Oklahoma

□ Wyoming

□ Kansas

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05291

Reg. Dist. No.

5314

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b PASADENA 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY AA		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 126, Rt 2				d. STREET ADDRESS Box 126, Rt 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				5-30-1904	53 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
OFFICE WORKER		SPONGE RUBBER FACT		RICHMOND, VA		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
JOHN MATTHEW LEAVY		ALICE ALLISON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		170-05-9134		ALICE LEAVY, Rt 2, Box 126, PASADENA				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		LUNG CARCINOMA WITH						
163X								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		METASTASES IN BONES OF } 1 year						
(b)		VERTEBRAE & PELVIS						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		none					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from SEPTEMBER 5, 1958, to 5-1-1958, that I last saw the deceased alive on 5-1-1958, and that death occurred at 6:49 PM, from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		M.D.					DATE SIGNED	
OTTO VOGEL M.D.							Box 441-A 5-27-58	
PHYSICIAN'S NAME (Type)		OTTO VOGEL M.D.					PAZADENA, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)		
Burial		5/31/58		New Cathedral Cemetery		Baltimore, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
John A. Moran-3000 E. Baltimore Street				DATE JUN 2 '58		Alt. Leach		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05292

5315

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1515 Bruce Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Louisa</b>	Middle	Last <b>Lee</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>8</b>	Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886</b>	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dyson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Murray</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442 X</b> DUE TO Uremia	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>—</b>		(b) DUE TO Pyelonephritis with Renal Failure		(c) DUE TO Hypertensive Cardiovascular-Renal Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senility and Blindness</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>4/30</b> , 19 <b>58</b> , to <b>5/8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/8</b> , 19 <b>58</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lionell McHenry Mapp, M.D.</i>	ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>				DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>Lionell McHenry Mapp, M.D.</b>	Crownsville State Hospital, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>5/13/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>W. Md. Med. School</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Rees #108 Wash. St. Annapolis, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>MAY 15 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Rees</i>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held with the registrar prior to burial, cremation, or removal, and in event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5269

Item 8 Film G229 5-19-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

05293

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ferndale (Glen Burnie, Md.)</i>		d. STREET ADDRESS <i>316 Ferndale Road</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Martha</i>		First	Middle	Last	4. DATE OF DEATH <i>Lee</i>	Month <i>May</i>	Day <i>9</i>	Year <i>1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 27, 1877</i>		9. AGE (In years last birthday) <i>85</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. Months <i>0</i>	14. Days <i>0</i>	15. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework (etc.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>(Unknown) Loving</i>		14. MOTHER'S MAIDEN NAME <i>(Unknown)</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Lee Gardner</i>		Address <i>Odenton, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i>											
446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerotic nephrosclerosis</i>											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. p.m. 19		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state) <i>68 Franklin St.</i>	(County)	(State)		
21. I certify that I attended the deceased from <i>5/7/1</i> , 1958, to <i>5/9</i> , 1958, that I last saw the deceased alive on <i>5/9</i> , 1958, and that death occurred at <i>12:45</i> P.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>John L. Henderson</i>		DATE SIGNED <i>5/9/58</i>									
PHYSICIAN'S NAME (Type)		ADDRESS <i>Annapolis, Md.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 13, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Brooklyn Rd., Md.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Washington</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Arthaud</i>					

COMMITTEE-HAZARD AND EMERGENCY STATUS QUALIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 05294

5316				
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn, Md.</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Quarterfield Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>LIRENE MARGARET LEIGHT</i>		First	Middle	
4. DATE OF DEATH <i>May 12, 1958</i>	Last	Month	Day	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 11, 1908</i>	
9. AGE (In years last birthday) <i>49</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days</i>	12. IF UNDER 24 HRS. <i>Hours</i>	
13. FATHER'S NAME <i>George L. Benton</i>	14. MOTHER'S MAIDEN NAME <i>Agnes Bortner</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>216-05-4694</i>	17. INFORMANT <i>Mr. John R. Leight</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Vascular Accident (Thrombosis) Migraine</i> <i>Generalized Arterio-sclerosis Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>9 1/2 hrs</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ p. m. _____	Month _____ 19	Day _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jeannette R. Hegganian, M.D.</i>	ADDRESS (Street, city or town, state) <i>2212 South Road, Baltimore, Md.</i>	DATE SIGNED <i>May 19, 1958</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 15, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Glen Haven Cemetery</i>	22d. LOCATION (City, town, or county) <i>Glen Burnie, Maryland</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. H. Hegganian</i>	ADDRESS <i>Glen Burnie, Md.</i>	24a. REC'D BY REGISTRAR <i>May 19 '58</i>	24b. REGISTRAR'S SIGNATURE <i>John H. Hegganian</i>	

ARMED FORCES STATE DEPARTMENT - BUREAU OF  
CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5270

## CERTIFICATE OF DEATH

Reg. Dist. No.

05295

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>aa</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>aa General</i>		d. STREET ADDRESS <i>140 Murray Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>B. Lincoln</i>	Last
4. DATE OF DEATH	Month <i>3</i>	Day <i>25</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-8-1892</i>
9. AGE (In years last birthday) <i>66</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	Months <i>0</i>	Days <i>0</i>
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pet Mech, Engineer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Y.S.A.E.S</i>	11. BIRTHPLACE (State or foreign country) <i>Keene N.H.</i>	12. CITIZEN OF WHAT COUNTRY? <i>N. S. A.</i>
13. FATHER'S NAME <i>Joseph A Lincoln</i>	14. MOTHER'S MAIDEN NAME <i>Mabel Welch</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Gertrude R. Lincoln</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyper tension Cardiovascular</i>
DUE TO <i>442 X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cardiovascular</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypertension</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i> (County) <i>MD</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>5/20</i> , 19 <i>58</i> to <i>5/25</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/25</i> , 19 <i>58</i> , and that death occurred at <i>1304 N.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward J. Beck</i>	ADDRESS (Street, city or town, state) <i>MD</i>		DATE SIGNED
PHYSICIAN'S NAME (Type) <i>John M. Taylor</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-26-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son Annapolis Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAY 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Albert E. Smith</i>

MARYLAND STATE GOVERNMENT HELD—SAVING

CERTIFICATE OF DEATH

NAME

DEATH DATE

DEATH PLACE

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

ADDRESS

PHONE NUMBER

RELATIONSHIP TO DECEASED

TELE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5271 CERTIFICATE OF DEATH

Reg. Dist. No. 05296

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena Md Chelsa Beach		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel County Hospital	d. STREET ADDRESS / 6 street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Beatrice	First	Middle	Last	
	E.	Maske	4. DATE OF DEATH May 4, Month Day Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1892	
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME William Mc Namara		14. MOTHER'S MAIDEN NAME Sarah E Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Nabel Coeyman Address Pasadena Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE 5 YEARS				
DUE TO (c)				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 DIABETES MELLITUS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/3, 1938, to 5/4, 1958, that I last saw the deceased alive on 5/4, 1958, and that death occurred at 5/4, 1958, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edward S Beck M.D. 34 Backville Rd Annapolis Md DATE SIGNED 5/4/58				
ACTUAL SIGNATURE <i>Edward S Beck</i>		PHYSICIAN'S NAME (Type) Edward S Beck		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	22d. LOCATION (City, town, or county) Arlington Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE May 12 '58	24b. REGISTRAR'S SIGNATURE <i>Debouch</i>

## CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD R. HARRIS	60	M	CHRONIC CARDIOPNEUMONIA
ADDRESS	STATE	TIME OF DEATH	TIME OF CERTIFICATION
1111 WOODSTOCK	ILLINOIS	10:00 A.M.	10:00 A.M.
DEATH CERTIFIED BY:			
DR. ROBERT L. COOPER			
LAWRENCE TOWNSHIP			
ILLINOIS			
JULY 1965			
RECORDED AND INDEXED JULY 1965			
REGISTRATION NO. 1022844			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5272

## CERTIFICATE OF DEATH

Reg. Dist. No. 05297

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Carola Mason

1. PLACE OF DEATH a. COUNTY <i>a a</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General Hospital</i>		e. STREET ADDRESS <i>'3 Shipwright Harbor</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Barbara</i>	Middle <i>Carola</i>	Last <i>Mason</i>	4. DATE OF DEATH <i>July 14 1958</i>	Month <i>July</i>	Day <i>11</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14 1896</i>	9. AGE (In years at time of death) <i>62 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Sir John Throgmorton Middlemore</i>		14. MOTHER'S MAIDEN NAME <i>Lady Mary Price</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Charles S. Bell</i>		Address <i>2</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fibromyxosarcoma of ovary</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 week</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>1750</i>		(c) DUE TO <i>—</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>68 Franklin St</i>	(County) <i>Annapolis Md</i>
21. I certify that I attended the deceased from <i>March</i> , 1958, to <i>May 11</i> , 1958, that I last saw the deceased alive on <i>May 11</i> , 1958, and that death occurred at <i>132 p</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>68 Franklin St Annapolis Md</i>							
ACTUAL SIGNATURE <i>John L. Hedeman</i>	M.D.				DATE SIGNED <i>5/11/58</i>		
PHYSICIAN'S NAME (Type) <i>John L. Hedeman</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>5-12-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>77 Lincoln Cemt</i>	22d. LOCATION (City, town, or county) <i>Prince Geo Co Md</i>	(State) <i>Md</i>			
22e. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>	ADDRESS <i>Annapolis Md.</i>	24a. REC'D BY REGISTRAR <i>May 13 58</i>	24b. REGISTRAR'S SIGNATURE <i>John L. Hedeman</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		5317 Anne Arundel Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X</i> <i>Anne Arundel</i>		d. STREET ADDRESS <i>/</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F</i>		<i>N</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>Divorced <input type="checkbox"/></i>	<i>May 4th 1885 73 yrs.</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
				<i>Md.</i>		<i>U.S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
<i>Isiah Stark</i>		<i>Louise Booze</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				<i>Mazora Wills Friendship</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>172x</i> DUE TO <i>Carcinoma corpus uteri</i> INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>generalized metastasis</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> (c) YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Emily H. Wilson</i>		DATE SIGNED						
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5-15-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Friendship</i>		22d. LOCATION (City, town, or county) <i>A. Arundel, Md.</i>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. G. Sewell, P. Frederick, Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR MAY 19 '58		24b. REGISTRAR'S SIGNATURE <i>W. L. Deuch</i>		
				DATE				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, removal, or removal.

*...REDCAP EXAMINER'S CERTIFICATE OF DEATH*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5273

## CERTIFICATE OF DEATH

Reg. Dist. No.

05299

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached and used as the burial-troupe permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE				
<i>a a</i>		MARYLAND <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY <i>a a</i>				
<i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<i>a a General</i>	<i>1171 Belvedere Hgts</i>					
3. NAME OF DECEASED (Type or print)	First <i>Catalina</i>	Middle <i>Messick</i>	Last <i>5 - 14 1958</i>			
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-14-58</i>			
Female <i>White</i>			9. AGE (In years last birthday) yrs. <i>2</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
<i>none</i>	<i>none</i>	<i>Annapolis Md.</i>	<i>U. S.A.</i>			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
<i>Carroll J. Messick</i>	<i>Elizabeth R. Worthington</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>Carroll J. Messick 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
<i>757.3</i>						
DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)						
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>May 14</i>	(County) <i>SEYRNA</i>	(State) <i>Park MD</i>
21. I certify that I attended the deceased from <i>May 14</i> , 1958, to <i>May 14</i> , 1958, that I last saw the deceased alive on <i>May 14</i> , 1958, and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>SEYRNA Park MD</i>	DATE SIGNED <i>5-18-58</i>	
ACTUAL SIGNATURE <i>Francis J. Codd M.D.</i>						
PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 17-1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's Comt</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>	ADDRESS <i>Annapolis Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 20 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Redick</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5318

## CERTIFICATE OF DEATH

Reg. Dist. No.

05300

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3 V O I - 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>39 S. Bond Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Marie</b>	Middle	Last <b>Miller</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>12</b>	Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3/26/99</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>422.1</b> (b) DUE TO <b>Congestive Heart Failure with Cardiac Decompensation</b> (c) DUE TO <b>Arteriosclerotic Cardiovascular Disease</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pyelonephritis with Uremia - Chronic Brain Syndrome with Arteriosclerosis</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>— 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>—</b>		(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>4/12/58</b> , 19 <b>58</b> , to <b>5/12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/12</b> , 19 <b>58</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>							DATE SIGNED <b>5/13/58</b>
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		Crownsville State Hospital, Md.							<b>5/13/58</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/16/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>CARVER MEM. PARK</b>		22d. LOCATION (City, town, or county) <b>Laurel</b>		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Milton E. Erickson</i>		ADDRESS <b>1129 N. CAROLINE ST.</b>		24a. REC'D BY REGISTRAR <b>MAY 15 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>3 m 25 d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Victoria</b>		d. STREET ADDRESS <b>08X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Charlie</b>	Middle <b></b>	Last <b>Monroe</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>23</b>	Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>1905?</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>193.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with CVA</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____		(County) _____	(State) _____
21. I certify that I attended the deceased from <b>1/28</b> , 19 <b>58</b> , to <b>5/23/</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/23/</b> , 19 <b>58</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Hildegard Reissmann</i>		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Hildegard Reissmann</b>		DATE SIGNED <b>5/23/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/27/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Crownsville</b>		22d. LOCATION (City, town, or county) <b>Crownsville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marie Anna M.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Deb. Resnick</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5320

## CERTIFICATE OF DEATH

Reg. Dist. No. 05303

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>ANN ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARUNDALE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARUNDALE</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2110 GOODWOOD ROAD</u>		e. STREET ADDRESS <u>2110 Goodwood, RD.</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John Lewellen Moore</u>		First <u>John</u>	Middle <u>Roland</u>	Last <u>Moore</u>	4. DATE OF DEATH <u>MAY 18 1958</u>	Month <u>MAY</u>	Day <u>18</u>	Year <u>1958</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17 1915</u>	9. AGE (In years last birthday) yrs. <u>43</u>	10. IF UNDER 1 YEAR Months <u>—</u>	11. IF UNDER 24 HRS. Days <u>—</u>	12. Hours <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabaffer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAFETY</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>John Lewellen Moore</u>		14. MOTHER'S MAIDEN NAME <u>MARY Mollie WINDSOR</u>		Address <u>2110 Goodwood</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-3020</u>		17. INFORMANT <u>KATHERINE MOORE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>178X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <u>Pulmonary Metastases</u> (b) DUE TO <u>Seminoma, Testicle, RT.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MAL NUTRITION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D. <u>715 Cotter Rd</u>	(County) <u>715 Cotter Rd</u>	(State) <u>MD</u>			
21. I certify that I attended the deceased from <u>5/18/58</u> , 1958, to <u>5/18/58</u> , 1958, that I last saw the deceased alive on <u>5/18/58</u> , 1958, and that death occurred at <u>715 Cotter Rd</u> , M.D., from the causes and on the date stated above. ACTUAL SIGNATURE <u>R.W. PRICHARD</u> ADDRESS (Street, city or town, state) <u>715 Cotter Rd</u> DATE SIGNED <u>5/18/58</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>WASHINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) <u>SUITLAND, MD.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington, DC</u>		ADDRESS <u>W.W. Chambers Co. Washington, DC</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>R. Leibach</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



18  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05303

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

5274

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Hanover</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Few seconds</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Sambrills</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>U.S. Naval Academy Dairy</b>		f. DATE OF DEATH <b>May 30th, 1958</b>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Robert Stevenson</b>	Middle <b>Stephen Moore</b>	Last	Month	Day	Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 16, 1897</b>	9. AGE (In years last birthday) <b>60 50 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant herdsman.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jim Rex Moore</b>		14. MOTHER'S MAIDEN NAME <b>Julia Jarman</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>220-16-7241</b>		17. INFORMANT <b>U.S. Naval Academy Dairy, Gambrills, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Academy Dairy, Gambrills, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED <b>5/30/58</b>					
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-1-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Bethel</b>		22d. LOCATION (City, town, or county) <b>Anson County</b> (State) <b>N. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Leath Jr.</i>		ADDRESS <b>Wadesboro, N. C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Alv. Louch</i>	

WEBCAM EXHIBITION 2 CELESTIAL DEPT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05304

5321

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>a a</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>		c. LENGTH OF STAY IN 1b <i>37 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>James Henry Moreland</i>		First	Middle	Last	4. DATE OF DEATH <i>May 2</i>	Month	Day	Year <i>1958</i>		
5. SEX <i>Male</i>		6. COLOR OF RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/28/98</i>	9. AGE (In years last birthday) <i>59 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Bristol Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Allegue Moreland Address Lothian Md.</i>				
13. FATHER'S NAME <i>Wm E. Moreland</i>		14. MOTHER'S MAIDEN NAME <i>Mirthe Moreland</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-14-2185</i>		17. INFORMANT <i>Allegue Moreland</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Address Lothian Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>		causis of the stomach								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Lothian</i>		(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from <i>2/1</i> , 19 <i>58</i> , to <i>5-2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-1</i> , 19 <i>58</i> , and that death occurred at <i>6 P. M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Lothian Md.</i>								DATE SIGNED <i>5-3-58</i>
ACTUAL SIGNATURE <i>Emily H. Vibem</i>		M.D.								
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/4/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Zion</i>		22d. LOCATION (City, town, or county) <i>Lothian</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bennie Daniels Galiville Md</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>MAY 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Debrauk</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05305

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gambrells</i>		d. STREET ADDRESS <i>Box 116</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				d. STREET ADDRESS <i>Box 116</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Donald</i>	Middle <i>Wayne</i>	Last <i>Musick</i>	4. DATE OF DEATH <i>May 13 1958</i>	Month <i>May</i>	Day <i>13</i>	Year <i>1958</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-13-58</i>	9. AGE (In years lost birthday) yrs. <i>6</i>	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>6</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Clarence D. Musick</i>		14. MOTHER'S MAIDEN NAME <i>Sheila Yegliss</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Clarence D. Musick #2</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Heart Disease</i> DUE TO <i>754.5</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>—</i>									
(c) DUE TO <i>—</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) <i>—</i>		(State) <i>—</i>	
21. I certify that I attended the deceased from <i>May 13, 1958</i> , to <i>May 13, 1958</i> , that I last saw the deceased alive on <i>May 13, 1958</i> , and that death occurred at <i>2:06 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Gambrells, Md.</i>			
ACTUAL SIGNATURE <i>Edmund J. Bennett</i>		M.D.				DATE SIGNED <i>5-14-68</i>			
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-15-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Holzer Cemetery</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Esq</i>		ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05306

5276

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE							
<i>Anne Arundel</i> MARYLAND		<i>Maryland</i> <i>Anne Arundel</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY							
<i>Annapolis, Md</i>		<i>Annapolis, Maryland</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
<i>None</i>	<i>Annapolis, Maryland</i>								
3. NAME OF DECEASED (Type or print)	First <i>Peter</i>	Middle <i>J.</i>	Last <i>Neimiller</i>	4. DATE OF DEATH <i>May 23</i>	Month <i>May</i>	Day <i>23</i>	Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov 17<sup>th</sup> 1892</i>	9. AGE (In years last birthday yrs.)	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sea food Store</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>William Neimiller</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lince B. Neimiller (2)</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Acute dilatation of the heart coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH <i>Immediatly</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>50</i> to <i>May 1</i> , 19 <i>52</i> that I last saw the deceased alive on <i>April 19 52</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <i>5/23/58</i>			
ACTUAL SIGNATURE <i>Albert L. Anderson</i>				M.D.					
PHYSICIAN'S NAME (Type) <i>ALBERT L. ANDERSON</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-26-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Son</i>		ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE MAY 27 '58		24b. REGISTRAR'S SIGNATURE <i>John W. Taylor</i>			

## STATE OF MARYLAND - BALTIMORE 18

## CERTIFICATE OF DEATH

MURKIN

1200 18TH ST.

TOMASO

John C. Murphy  
Murphy & Associates  
Attorneys at LawBALTIMORE  
MARYLANDDEPARTMENT  
OF PUBLIC SAFETY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5322

## CERTIFICATE OF DEATH

Reg. Dist. No.

05307

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>A.A.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FT MEADE</b>		c. LENGTH OF STAY IN lb <b>17 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George - G. Meade</b>		d. STREET ADDRESS <b>QTRS 2324-C and Bldg 2144</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US ARMY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>GUY</b>		First <b>Eugene</b>	Middle <b></b>	Last <b>PACKER</b>	4. DATE OF DEATH <b>May 27 1958</b>	Month <b>May</b>	Day <b>27</b>	Year <b>1958</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>22 June 1922</b>	9. AGE (In years lost birthday) <b>35 yrs.</b>	IF UNDER 1 YEAR <b>Months Days</b>	IF UNDER 24 HRS. <b>Hours Min.</b>		
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SOLDIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S ARMY</b>		12. CITIZEN OF WHAT COUNTRY? <b>WYMORE, NEB.</b>	
13. FATHER'S NAME <b>Clyde Packer</b>				14. MOTHER'S MAIDEN NAME <b>Sada Phillip</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1942-1958</b>		17. INFORMANT		Address		
MEDICAL EXAMINATION FOR REENLISTMENT FT MEADE								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary arteriosclerosis, severe</b> INTERVAL BETWEEN ONSET AND DEATH Sudden								
420.1 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:13 PM, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>815 AH, Fort George G. Meade, Md.</b> DATE SIGNED								
ACTUAL SIGNATURE <b>Joseph H. Williams</b> M.D.								
PHYSICIAN'S NAME (Type) <b>JOSEPH H. WILLIAMS, CAPT, MC</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/2/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Kinsley Mortuary</b>		22d. LOCATION (City, town, or county) <b>Marshall, Kansas</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carl B. Waberton Funeral Home, Inc.</b>		ADDRESS <b>6306 - Belair Rd, Baltimore - 6 - Md</b>		24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>		



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5277 CERTIFICATE OF DEATH

Reg. Dist. No.

05308

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Anne Arundel</i> MARYLAND		a. STATE <i>Md.</i>	b. COUNTY <i>A. C. C.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis 10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Gen. Hosp.</i>		d. STREET ADDRESS <i>105 1/2 Tucker St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Sharyl Lynn</i>	Middle <i>Poland</i>
		Last <i>May</i>	4. DATE OF DEATH Month Day Year <i>May 15 1958</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		B. DATE OF BIRTH <i>May 15 1938</i>	
7. AGE (In years last birthday) yrs.		8. IF UNDER 1 YEAR Months <i>5</i>	9. IF UNDER 24 HRS. Days <i>5</i> Hours <i>5</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Harold Poland</i>		14. MOTHER'S MAIDEN NAME <i>Jeanette Washington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>7625</i>		16. SOCIAL SECURITY NO. <i>Harold Poland</i>	
17. INFORMANT <i>Address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Atelectasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/15</i> , 19 <i>58</i> to <i>5/15</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/15</i> , 19 <i>58</i> , and that death occurred at <i>5:45 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert A. Riley Jr.</i> M.D. PHYSICIAN'S NAME (Type) <i>ROBERT A. RILEY JR</i> ADDRESS (Street, city or town, state) <i>69 FRANKLIN ST ANNAPOLIS, MD.</i> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>3-19-58</i>		22b. DATE THEREOF <i>Hillcrest Mem.</i>	22c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son Annapolis</i>		ADDRESS <i>2063161XV2</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 20 1958</i>
		24b. REGISTRAR'S SIGNATURE <i>Rebekah</i>	

STATE OF MARYLAND - DEPARTMENT OF HEDMAN - BALTIMORE STATE INSURANCE  
CERTIFICATE OF DEATH

DEATH

DEATH CERTIFICATE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5323

## CERTIFICATE OF DEATH

05309

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>a a</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>	c. LENGTH OF STAY IN 1b <i>91 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First <i>George</i> Middle <i>Wesley</i> Last <i>Proctor</i>	
4. DATE OF DEATH	Month <i>May</i>	Day <i>16</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 23 1866</i>
9. AGE (In years last birthday) <i>92 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Shadyside Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Shadyside Md.</i>
13. FATHER'S NAME <i>Jones</i>	14. MOTHER'S MADDEN NAME <i>Harriet A Lee</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Harry Proctor Shadyside Md.</i>	Address <i>Shadyside Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>782.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hepatitis &amp; Heart Failure Hepatitis - Truncation</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Shadyside, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/14</i> , 19 <i>58</i> , to <i>5/16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 16, 1958</i> , and that death occurred at <i>4302 M</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Shadyside, Md.</i>	DATE SIGNED <i>5/16/58</i>
ACTUAL SIGNATURE <i>R.H. Johnson</i>	PHYSICIAN'S NAME (Type) <i>John H. Johnson</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	
22b. DATE THEREOF <i>5/19/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns</i>	22d. LOCATION (City, town, or county) <i>Shadyside</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty Hallmark Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 6 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

HAROLD D. HARRIS

Died  
in  
HOSPITAL

DECEASED PERSON'S NAME: JOHN W. HARRIS  
SEX: M  
AGE: 65  
DATE OF BIRTH: NOVEMBER 12, 1874  
PLACE OF BIRTH: NEW YORK  
NAME AND ADDRESS OF PERSON REPORTING: HAROLD D. HARRIS  
RELATIONSHIP: SON

HAROLD  
D. HARRISHAROLD  
D. HARRIS

DECEASED PERSON'S NAME: JOHN W. HARRIS

HAROLD  
D. HARRISHAROLD  
D. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, File G229, 5/16/58

5324

## CERTIFICATE OF DEATH

05310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brownsville</i>		c. LENGTH OF STAY IN 1b <i>4/17/58</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brownsville State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First Charles</i>		4. DATE OF DEATH <i>Queen</i>	Month <i>5</i>
S. SEX <i>m</i>	6. COLOR OR RACE <i>c</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/23/1885</i>
9. AGE (In years lost birthday) yrs. <i>73</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>20</i> Hours <i>10</i> Min. <i>58</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>law career</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Queen Jr.</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <i>450.0</i> (b) <i>generalized arteriosclerosis and chronic brain syndrome</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/17</i> , 19 <i>58</i> , to <i>5/10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4/17/58</i> , 19 <i>58</i> , and that death occurred at <i>5/10/58</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>L. Benedict M.D.</i>		ADDRESS (Street, city or town, state) <i>Crownsville State Hospital</i>	
PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>		DATE SIGNED <i>8/10/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/15/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Calvary</i>		22d. LOCATION (City, town, or county) (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George S. Nelson</i>		ADDRESS <i>1348 W. Calhoun St</i>	
24a. REC'D BY REGISTRAR <i>MAY 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

תְּמִימָנֶה וְמִשְׁמָנֶה  
תְּמִימָנֶה וְמִשְׁמָנֶה

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

05311

5325

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Pulaski</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>2 y. 9 m.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dublin</b>		d. STREET ADDRESS <b>Route 2 Box 81</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Children's Center (Federal Institution)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>BASCUME</b>		First <b>BASCUME</b>	Middle <b>L.</b>	Lost <b>ROOPE</b>	4. DATE OF DEATH <b>May 25 1958</b>	Month <b>May</b>	Doy <b>25</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>8/10/16</b>		9. AGE (In years last birthday) <b>41 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pulaski County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Samuel H. Roope</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Albert</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>E. R. Alley (brother-in-law)</b>		Address <b>Dublin, Va.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> INTERVAL BETWEEN ONSET AND DEATH <b>976X</b>								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self in head</b>								
20c. TIME OF INJURY Hour <b>3</b>		o. m. <b>5/25</b>	20d. INJURY OCCURRED at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Laurel</b>	(County) <b>A.A. County</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5/26/58</b>				
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>5-26-58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>PULASKI, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAY 27 '58</b>		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>		
VS. A15ME SM 2/57								

EXAMINER CERTIFICATE OF DEATH

STATE OF

State

County

Municipality

City

NAME TO BE USED

DECEASED PERSON'S NAME

DATE OF DEATH

AGE AT DEATH

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF NURSE

8-8-8

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. A should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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V.S. A15ME  
SM 2/57

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05312

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Anne Arundel MARYLAND		a. STATE Same	b. COUNTY Same
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Jessups	6 years.	X Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Box 406 Maple Avenue.		Same	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
John Andrew Schultz			
4. DATE OF DEATH	Month	Day	Year
May 30th,			1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M.	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/6/93
9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Boilermaker.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Andrew Schultz.		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) Navy First World War.		16. SOCIAL SECURITY NO. 173-10-7981	17. INFORMANT Mrs. Agnes Ruth Schultz (wife)
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden 420.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)	Gustave H. Faubert, M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/1/58	22c. NAME OF CEMETERY OR CREMATORIAL Whittet Family Cemetery
			22d. LOCATION (City, town, or county) Weaverville, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE James Kirkley		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 3 '58
			24b. REGISTRAR'S SIGNATURE Albert Faubert



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 05313			
5327 CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Not</i> b. COUNTY <i>Baltimore City</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CROWNSVILLE</i>				c. LENGTH OF STAY IN lb <i>12/18/57</i>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CROWNVILLE STATE HOSPITAL</i>				e. STREET ADDRESS <i>3032 CENTRAL AVE</i>											
3. NAME OF DECEASED (Type or print) <i>RICHARD</i>				First <i>RICHARD</i>			Middle <i>SURRY</i>		Last <i>SCURRY</i>		4. DATE OF DEATH <i>May 29 1958</i>	Month <i>May</i>	Day <i>29</i>	Year <i>1958</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <i>JULY 8 1927</i>		9. AGE (In years last birthday) <i>30 yrs.</i>		IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Days <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEAMAN</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>FLORIDA</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Richard Scurry</i>				14. MOTHER'S MAIDEN NAME <i>Fannie Scurry</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No -</i>				16. SOCIAL SECURITY NO.				17. INFORMANT				Address <i>Sister Fannie Scurry P. Box 309</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>353.2</i>												INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) STATUS EPILEPTICUS</i>															
DUE TO <i>(c) EPILEPSY - CNS SYPHILIS</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>026x</i>												19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>CROWNVILLE</i>		(County) <i>ARUNDEL Co.</i>		(State) <i>Md</i>			
21. I certify that I attended the deceased from <i>12/18</i> , 19 <i>57</i> , to <i>5/29</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/24/58</i> , 19 <i>58</i> , and that death occurred at <i>11:05 PM</i> , from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <i>CROWNVILLE STATE HOSPITAL</i>			
ACTUAL SIGNATURE <i>H. Benedict M.D.</i>				M.D.				DATE SIGNED							
PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>				22c. NAME OF CEMETERY OR CREMATORIAL <i>MARLEY NECK</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				22b. DATE THEREOF <i>6/3/58</i>		22d. LOCATION (City, town, or county) <i>ARUNDEL Co. Md</i>									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sarah L. Grant</i>				ADDRESS <i>108 W MONTGOMERY ST</i>		24a. REC'D BY REGISTRAR <i>104 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Anne Scurry</i>							

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05314

5328

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN lb <b>4yr. 5m. 25d.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>			d. STREET ADDRESS <b>1712 W. North Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First <b>Augusta</b>	Middle <b>Lydia</b>	Last <b>Smith</b>	4. DATE OF DEATH			Month <b>5</b>	Day <b>1</b>	Year <b>19 58</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <b>5/11/93</b>	9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure and Cardiac Decompensation</b>											
442 X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Renal Disease</b>											
(c) <b>Pyelonephritis and Senility with Uremia</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month Day Year Hour a. m. _____ p. m. _____ 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July, 19 56</b> , to <b>May 1, 19 58</b> , that I last saw the deceased alive on <b>May 1, 19 58</b> , and that death occurred at <b>8:25 PM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Ronald H. Mapp, M.D.</i> ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Maryland</b> DATE SIGNED											
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>			Crownsville State Hospital, Maryland								
22a. FUNERAL, CREMATION OR REMOVAL (Specify) <b>Funeral 5-5-1958 24. c. m.d.</b>			22b. DATE THEREOF <b>24. c. m.d.</b>			22c. NAME OF CEMETERY OR CEMATORIAL <b>Beth. M. -</b>			22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Beseid - Annapolis.</b>			ADDRESS			24a. REC'D BY REGISTRAR DATE <b>MAY 7 '58</b>			24b. REGISTRAR'S SIGNATURE <b>John E. Lee</b>		

1. ESTATE-TRUSTS-TESTAMENTARY TRUSTS

DEFINITION OF CHARTER

• D.R. M.L.D.

June 15, 1961-2 hours  
LAWSON - REED M.L.D.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05315

5278

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Anne Arundel</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>X Severna Park Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Anne Arundel Gen Hosp</i>		<i>OLD Annapolis BLVD &amp; Lower Margaret Rd.</i>	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Margaret</i>		<i>Stinchcomb</i>	<i>L</i>
4. DATE OF DEATH		Month	Day Year
<i>May 25 1958</i>		<i>Month</i>	<i>Day Year</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>F</i>		<i>W</i>	<i>Dec 1873.</i>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS.
<i>84</i>		<i>84 yrs</i>	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		<i>Horne</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>BALTO.</i>		<i>U.S.</i>	
13. FATHER'S NAME		14. MOTHER'S-MAIDEN NAME	
<i>Steven Waters.</i>		<i>Catherine</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>None</i>	
17. INFORMANT		Address	
<i>Son, Salmon Stinchcomb</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Congestive Heart Failure</i>	
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO	
{		<i>Arteriosclerotic C.V. Disease.</i>	
(b)		DUE TO	
{		<i>Generalized Arteriosclerosis.</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> , <i>4</i> , <i>19</i> , to <i>1958</i> , <i>19</i> , that I last saw the deceased alive on <i>5-24-58</i> , <i>1958</i> , and that death occurred at <i>2A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert R. Hahn</i> PHYSICIAN'S NAME (Type) <i>Robert R. HAHN</i>		ADDRESS (Street, city or town, state) <i>Severna Park Md.</i> DATE SIGNED <i>5-25-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>May 28, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) (State)	
<i>Meadowridge Mem. Pk.</i>		<i>Howard Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>R. J. Singleton Glen Burnie, Md.</i>		24b. REGISTRAR'S SIGNATURE DATE <i>MAY 28 '58</i>	



**FOR STATE  
HEALTH DEPT.**

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page 5 may be retained for your files.

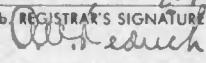
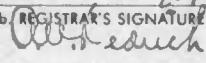
**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health in its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05316

**Reg. Dist. No.**

1. PLACE OF DEATH o. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
Anne Arundel MARYLAND			o. STATE D. C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓	
Shoreham Beach				WASHINGTON 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WALDEMAR	Middle	Lost STRAUSS	Month May Day 13, Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min. U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Albert Strauss		14. MOTHER'S MAIDEN NAME Tilda Strauss		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W. W. II		16. SOCIAL SECURITY NO. W. W. II		17. INFORMANT A.A.C. Police Edgewater Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hose attached to exhaust of auto into front door					
20c. TIME OF INJURY Month, Day, Year Hour <input checked="" type="checkbox"/> p. m. 5/11/58		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street partial Shoreham Beach Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Unknown		22c. NAME OF CEMETERY OR CREMATORIUM Freshmane	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS		22d. LOCATION (City, town, or county) Boston (State) MASS. JUN 2 1958	
24a. REC'D. BY REGISTRAR 		24b. REGISTRAR'S SIGNATURE 			
MEDICAL CERTIFICATION					

VS. A15ME  
5M 2/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG229 6-2-58 et

05317

5279

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a.a.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		b. COUNTY <i>a.a.</i>	
c. LENGTH OF STAY IN 1b <i>183 Prince Geo St</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>183 Prince George St</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>183 Prince Geo St</i>		d. STREET ADDRESS <i>183 Prince George St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Annie</i>	Middle <i>E.</i>	Last <i>Taylor</i>
4. DATE OF DEATH	Month <i>5</i>	Day <i>21</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-30-1870</i>
9. AGE (In years (or birthday) yrs.) <i>87 1/2</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	14. FATHER'S NAME <i>Bernard Ludholz</i>	15. MOTHER'S MAIDEN NAME <i>Gretchen Baier</i>	Address <i>2</i>
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>153.8</i>	17. SOCIAL SECURITY NO. <i>- - -</i>	18. INFORMANT <i>Martha T. Adams</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO <i>153.8</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Cancer of Large Bowel</i> DUE TO <i>137.1</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 4, 1958</i> to <i>5-21-58</i> , that I last saw the deceased alive on <i>5-21-58</i> , and that death occurred at <i>145 M</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James R. Martin</i> M.D. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-24-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Son</i>	ADDRESS <i>Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 26 '58</i>	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05318

5330

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Passadena</b>		c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Passadena</b>		d. STREET ADDRESS -----	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Esther</b>	Middle -----	Last <b>Tolliver</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>25</b>	Year <b>19 58</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1880</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>78</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Madison Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Tolliver</b>		14. MOTHER'S MAIDEN NAME <b>Betty Tolliver</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William Brown # 4222 Evans Chapel Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac decompensation</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular disease</b> (c) <b>Hypertension, moderate, essential</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>several years</b> <b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 1, 1958</b> to <b>May 25, 1958</b> , that I last saw the deceased alive on <b>May 23, 1958</b> , and that death occurred at <b>7:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. M. McLaughlin</b>		M.D.		ADDRESS (Street, city or town, state) <b>Pasadena P.O. Maryland</b>		DATE SIGNED <b>May 25, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 29, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS <b>802 Madison Avenue</b>		24a. REC'D BY REGISTRAR <b>JUN 2 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Walsh</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5331 CERTIFICATE OF DEATH

Reg. Dist. No.

05319

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD b. COUNTY MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Trutesville		c. LENGTH OF STAY IN 1b 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ODEN EDWARD TUCKER		First	Middle
		Last	
4. DATE OF DEATH MAY 15 1958		Month	Year
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH		9. AGE (in years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Davidsonville Md.		12. CITIZEN OF WHAT COUNTRY? Ridgeway	
13. FATHER'S NAME William Tucker		14. MOTHER'S MAIDEN NAME Frances Tucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 05 0067	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Chronic C.V.A., desire (c) DUE TO Chronic nephritis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26, 1958, to May 15, 1958, that I last saw the deceased alive on May 15, 1958, and that death occurred at 205 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Shirley H. Lubin M.D. ADDRESS (Street, city or town, state) Latteon, Md. DATE SIGNED 5-17-58		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) 130 V 151 5-18-58	
22b. DATE THEREOF 5-18-58		22c. NAME OF CEMETERY OR CREMATORIUM TUCKER	
22d. LOCATION (City, town, precinct) Trutesville		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Shirley Hardisty Galvin's test		24a. REC'D BY REGISTRAR DATE JUN 6 '58	
		24b. REGISTRAR'S SIGNATURE Shirley Hardisty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05320

Reg. Dist. No.

1		5332		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31		32		33		34		35		36		37		38		39		40		41		42		43		44		45		46		47		48		49		50		51		52		53		54		55		56		57		58		59		60		61		62		63		64		65		66		67		68		69		70		71		72		73		74		75		76		77		78		79		80		81		82		83		84		85		86		87		88		89		90		91		92		93		94		95		96		97		98		99		100		101		102		103		104		105		106		107		108		109		110		111		112		113		114		115		116		117		118		119		120		121		122		123		124		125		126		127		128		129		130		131		132		133		134		135		136		137		138		139		140		141		142		143		144		145		146		147		148		149		150		151		152		153		154		155		156		157		158		159		160		161		162		163		164		165		166		167		168		169		170		171		172		173		174		175		176		177		178		179		180		181		182		183		184		185		186		187		188		189		190		191		192		193		194		195		196		197		198		199		200		201		202		203		204		205		206		207		208		209		210		211		212		213		214		215		216		217		218		219		220		221		222		223		224		225		226		227		228		229		230		231		232		233		234		235		236		237		238		239		240		241		242		243		244		245		246		247		248		249		250		251		252		253		254		255		256		257		258		259		260		261		262		263		264		265		266		267		268		269		270		271		272		273		274		275		276		277		278		279		280		281		282		283		284		285		286		287		288		289		290		291		292		293		294		295		296		297		298		299		300		301		302		303		304		305		306		307		308		309		310		311		312		313		314		315		316		317		318		319		320		321		322		323		324		325		326		327		328		329		330		331		332		333		334		335		336		337		338		339		340		341		342		343		344		345		346		347		348		349		350		351		352		353		354		355		356		357		358		359		360		361		362		363		364		365		366		367		368		369		370		371		372		373		374		375		376		377		378		379		380		381		382		383		384		385		386		387		388		389		390		391		392		393		394		395		396		397		398		399		400		401		402		403		404		405		406		407		408		409		410		411		412		413		414		415		416		417		418		419		420		421		422		423		424		425		426		427		428		429		430		431		432		433		434		435		436		437		438		439		440		441		442		443		444		445		446		447		448		449		450		451		452		453		454		455		456		457		458		459		460		461		462		463		464		465		466		467		468		469		470		471		472		473		474		475		476		477		478		479		480		481		482		483		484		485		486		487		488		489		490		491		492		493		494		495		496		497		498		499		500		501		502		503		504		505		506		507		508		509		510		511		512		513		514		515		516		517		518		519		520		521		522		523		524		525		526		527		528		529		530		531		532		533		534		535		536		537		538		539		540		541		542		543		544		545		546		547		548		549		550		551		552		553		554		555		556		557		558		559		560		561		562		563		564		565		566		567		568		569		570		571		572		573		574		575		576		577		578		579		580		581		582		583		584		585		586		587		588		589		590		591		592		593		594		595		596		597		598		599		600		601		602		603		604		605		606		607		608		609		610		611		612		613		614		615		616		617		618		619		620		621		622		623		624		625		626		627		628		629		630		631		632		633		634		635		636		637		638		639		640		641		642		643		644		645		646		647		648		649		650		651		652		653		654		655		656		657		658		659		660		661		662		663		664		665		666		667		668		669		670		671		672		673		674		675		676		677		678		679		680		681		682		683		684		685		686		687		688		689		690		691		692		693		694		695		696		697		698		699		700		701		702		703		704		705		706		707		708		709		710		711		712		713		714		715		716		717		718		719		720		721		722		723		724		725		726		727		728		729		730		731		732		733		734		735		736		737		738		739		740		741		742		743		744		745		746		747		748		749		750		751		752		753		754		755		756		757		758		759		760		761		762		763		764		765		766		767		768		769		770		771		772		773		774		775		776		777		778		779		780		781		782		783		784		785		786		787		788		789		790		791		792		793		794		795		796		797		798		799		800		801		802		803		804		805		806		807		808		809		810		811		812		813		814		815		816		817		818		819		820		821		822		823		824		825		826		827		828		829		830		831		832		833		834		835		836		837		838		839		840		841		842		843		844		845		846		847		848		849		850		851		852		853		854		855		856		857		858		859		860		861		862		863		864		865		866		867		868		869		870		871		872		873		874		875		876		877		878		879		880		881		882		883		884		885		886		887		888		889		890		891		892		893		894		895		896		897		898		899		900		901		902		903		904		905		906		907		908		909		910		911		912		913		914		915		916		917		918		919		920		921		922		923		924		925		926		927		928		929		930		931		932		933		934		935		936		937		938		939		940		941		942		943		944		945		946		947		948		949		950		951		952		953		954		955		956		957		958		959		960		961		962		963		964		965		966		967		968		969		970		971		972		973		974		975		976		977		978		979		980		981		982		983		984		985		986		987		988		989		990		991		992		993		994		995		996		997		998		999		1000	
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WILHELM BERNHARD GERMANY - DEATH

1945

NAME	WILHELM BERNHARD
SEX	Male
AGE	40
DATE OF BIRTH	1905-01-01
DEATH DATE	1945-04-15
CAUSE OF DEATH	Execution
RELIGION	Protestant
EDUCATION	Elementary school
PROFESSION	Miner
ADDRESS	1234567890
RELATIVES	None
APPEAL	No appeal
INVESTIGATION	None
EXAMINATION	None
POSTMORTEM	None
ANATOMY	None
TESTIMONY	None
EXAMINER	None
WITNESSES	None
REMARKS	None

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5280

## CERTIFICATE OF DEATH

Reg. Dist. No.

05321

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE							
a a MARYLAND		N. C. b. COUNTY Duplin							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Annapolis		Warsaw 70 x .3							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS								
O. O. General									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
63	3. NAME OF DECEASED (Type or print)		First Robert	Middle Earle	Last Wall	4. DATE OF DEATH	Month 5	Day 29	Year 1958
	5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
	Male	White		11-25-1887	70				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?						
Auto Dealer		Bush Lodge Md	N. J. A						
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME								
William Wall	Dade								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address						
		Nena J. Wall Warsaw N. C.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO 2 HOURS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE 10 YRS DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? PEPTIC ULCER YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 24 MAY, 1958, to 29 MAY, 1958, that I last saw the deceased alive on 29 MAY, 1958, and that death occurred at 540P M, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
DATE SIGNED 3/29/58									
ACTUAL SIGNATURE Edward S. Beck M.D. 41 Southgate Ave									
PHYSICIAN'S NAME (Type) EDWARD S BECK ANNAPOLIS MD.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-58		22c. NAME OF CEMETERY OR CREMATORIUM Pinecrest		22d. LOCATION (City, town, or county) Warsaw		(State) N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS									
Quinn - McGowen & Son, Warsaw, N.C. ADDRESS									
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE JUN 4 '58 Aufmrich									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5333

## CERTIFICATE OF DEATH

Reg. Dist. No.

05322

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Anne Arundel Maryland</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Margate Md</i>	<i>2 yrs</i>	<i>Margate Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Lamar Drive</i>	<i>Lamar Drive</i>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Arthur</i>		<i>Watson</i>	<i>May</i>
4. DATE OF DEATH	Month	Day	Year
<i>4/20/1874</i>	<i>84</i>	<i>17</i>	<i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male</i>	<i>white</i>	<i>4/20/1874</i>	9. AGE (In years, lost birthday, yrs.) <i>84</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>watchman</i>	<i>Friendly Inn</i>	<i>California</i>	<i>U.S.A</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Unknown</i>	<i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>yes</i>		<i>Hrs Catherine Wheeler, same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cerebral Hemorrhage</i>	
4/20/1874 DUE TO		<i>4 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		?	
(b)		?	
DUE TO		?	
(c)		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>Mar</i> , 19 <i>58</i> , to <i>May 16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 16</i> , 19 <i>58</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry Glazman</i>		ADDRESS (Street, city or town, state) <i>2687 River Ave</i>	
PHYSICIAN'S NAME (Type) <i>Henry Glazman</i>		DATE SIGNED <i>Glazman</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/20/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Cross Cemetery</i>
			22d. LOCATION (City, town, or county) <i>Ritchie Highway, Md.</i>
			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Conner Son &amp; Galliher</i>		24a. RECEIVED BY REGISTRAR <i>MAY 20 1958</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>
		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANHATTAN STATE GOVERNMENT - ESTIMATE FOR

1952 CERTIFICATE OF DEATH

RECEIVED IN

MAY 1952

REGISTRATION NO.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05323

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission). o. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Odenton</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Severn</b>		d. STREET ADDRESS <b>/</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Atlantis Gas Station (Boontown)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Chester</b>	Middle <b>Glenn</b>	Last <b>Weed</b>	4. DATE OF DEATH	Month <b>May</b>	Day <b>29</b>	Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> Nov. 6, 1909</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank M. Weed</b>				14. MOTHER'S MAIDEN NAME <b>Florence A. Weed</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b> <b>218-09-2222</b>		17. INFORMANT <b>Harry Weed</b>		Address <b>Odenton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Coronay Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Odenton</b>	(County) <b>Maryland</b>	(State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <b>5/31/58</b>
220. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22d. DATE THEREOF <b>June 2-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cemetery Epiphany Episcopal ch</b>	22d. LOCATION (City, town, or county) <b>Odenton Maryland</b>		(State) <b>MD</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. V. Singletton</i>	ADDRESS <b>Glen Burnie, Md.</b>	24a. REC'D BY REGISTRAR <b>JUN 3 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Alleson</i>				
VS. AT 5ME 5M 2/57							



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5335

## CERTIFICATE OF DEATH

Reg. Dist. No. 05324

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>6yr. 10m. 10d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <i>3101-4</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b></b>	Last <b>White</b>	4. DATE OF DEATH	Month <b>5</b>	Day <b>8</b>	Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>James White</b>		14. MOTHER'S MAIDEN NAME <b>Martha</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b>									
DUE TO <b>Hypostatic Pneumonia</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Left Hemiplegia</b>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Chronic Brain Syndrome associated with Arteriosclerosis									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>1/6/55</b> , 19 <b>55</b> , to <b>5/8/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/8/58</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Maryland</b>									DATE SIGNED <b>5/8/58</b>
ACTUAL SIGNATURE <i>Hildegard Reissmann</i>		M.D.							
PHYSICIAN'S NAME (Type) <b>Hildegarde Reissmann, M. D.</b>		Crownsville State Hospital, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal 5-9-58</b>		22b. DATE THEREOF <b>21.05.58</b>		22c. NAME OF CEMETERY OR Crematory <b>Md. Medical</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Giese, D-Angus, Md.</i>		ADDRESS <b></b>		24a. REC'D BY REGISTRAR <b></b>		24b. REGISTRAR'S SIGNATURE <i>W. L. Schuck</i>		DATE <b>MAY 12 '58</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05325

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN 1b <i>15 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Glen Burnie</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>417 Pine Terrace</i>		d. STREET ADDRESS <i>1417 Pine Terrace</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Arthur</i>	Middle <i>H-</i>	Last <i>Whittington, Sr.</i>	4. DATE OF DEATH <i>May 10, 1958</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug. 9, 1892</i>	9. AGE (In years less birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pie Dealer (etc.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A + P Bakery</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Whittington</i>		14. MOTHER'S MAIDEN NAME <i>Florence Thomas</i>		Address <i>Samuel St 2</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-05-0041</i>		17. INFORMANT <i>Mrs. Annie Whittington</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr. 2 AM - 2:30 AM</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>51</i> , to <i>May 10</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 6</i> , 19 <i>58</i> , and that death occurred at <i>2:30 AM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>Ritchie Hwy</i>							
DATE SIGNED <i>Baltimore, May 12, 1958</i>							
MEDICAL CERTIFICATION							
ACTUAL SIGNATURE <i>Andrew R. Sosnowski</i>							
PHYSICIAN'S NAME (Type) <i>Andrew R. Sosnowski M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>May 13, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cem.</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edington</i>		ADDRESS <i>Glen Burnie, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

STATE OF NEW YORK - GOVERNOR

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5281

## **CERTIFICATE OF DEATH**

**Reg. Dist. No.**

.05326

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Annapolis</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>				<i>Beverly Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. George's General</i>			d. STREET ADDRESS <i>1 Mayo Rd</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Walter P. Winecoff</i>		First	Middle	Last	4. DATE OF DEATH <i>Oct. 5</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5</i>	9. AGE (In years last birthday) yrs. <i>65</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electrical Equip.</i>		11. BIRTHPLACE (State or foreign country) <i>Concord N.C.</i>	
13. FATHER'S NAME <i>Rev. J. E. L. Winecoff</i>		14. MOTHER'S MAIDEN NAME <i>Metta Gillon</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Mary E. Winecoff</i> Address <i>②</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneous subarachnoid hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs.</i> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Urinary retention due to benign prostatic hyperrophy</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Blow to head</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 16, 1958</i> to <i>May 12, 1958</i> , that I last saw the deceased alive on <i>May 17, 1958</i> , and that death occurred at <i>1145 P.M.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>68 Franklin</i> DATE SIGNED <i>5/18/58</i>					
ACTUAL SIGNATURE <i>John L. Hedeman</i>		M.D.			
PHYSICIAN'S NAME (Type) <i>JOHN L. HEDEMAN</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-21-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Annapolis Md.</i>	
22d. LOCATION (City, town or county) <i>Greensburg Pa</i>					
22e. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		22f. REC'D BY REGISTRAR <i>MAY 20 '58</i>	
				22g. REGISTRAR'S SIGNATURE <i>Albert E. Cook</i>	

01-38001144-HYDRAULIC METERING SYSTEMS OF ILLINOIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5282

## CERTIFICATE OF DEATH

Reg. Dist. No. 05327

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNA POLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CROWNSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSP.</b>		d. STREET ADDRESS <b>Harold Harbor</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>OLIVE</b>	Middle <b>E.</b>	Last <b>YOUNG</b>
4. DATE OF DEATH	Month <b>MAY</b>	Day <b>5,</b>	Year <b>19 58</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-94</b>
9. AGE (In years last birthday) <b>64</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Francis S. Young</b>		14. MOTHER'S MAIDEN NAME <b>Althaeretta Cranford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>214-38-7583</b>	17. INFORMANT <b>Mr Albert E. Young- 933 N. Linwood Ave, Baltimore</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Intestinal obstruction			
Operation for:-		6 days	
Carcinoma of cecum		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-19-58</b> , 19_____, to <b>5-5-58</b> , 19_____, that I last saw the deceased alive on <b>5-5-58</b> , 19_____, and that death occurred at <b>3:20A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jesse L. Wilkins</b> M.D. <b>98 CATHEDRAL ST.,</b> <b>5-5-58</b>			
ACTUAL SIGNATURE		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>JESSE L. WILKINS, M.D.</b>		ANNA POLIS, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>	ADDRESS <b>Annapolis, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>MAY 8 '58</b>	24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>

SI-38004100-FINANZEN FÜR DIE STABILISATION DER WIRTSCHAFT

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5337

## CERTIFICATE OF DEATH

Reg. Dist. No.

05328

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be retained by the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Anne Arundel</i>				a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lowell</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federal</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Children's Center</i>				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>ZELLA</i>	Middle <i>Z.</i>	Last <i>Reigler</i>	4. DATE OF DEATH	Month <i>May</i> Day <i>5</i> Year <i>1958</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years from last birthday) yrs. <i>61</i>	IF UNDER 1 YEAR Months <i>6</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Children's Center</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Martinsburg, W. Va.</i>	
13. FATHER'S NAME <i>Ralph Reigler</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Walker</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>acute myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary occlusion</i>		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Martinsburg</i> (County) <i>West Virginia</i> (State) <i>WV</i>	
21. I certify that I attended the deceased from <i>May 5, 1958</i> to <i>May 5, 1958</i> that I last saw the deceased alive on <i>May 5, 1958</i> , and that death occurred at <i>10:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Laurel Maryland</i> DATE SIGNED <i>May 5, 1958</i>					
ACTUAL SIGNATURE <i>Robert C. Wingfield</i>		M.D.			
PHYSICIAN'S NAME (Type) <i>ROBERT C. WINGFIELD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 8, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rosedale Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Martinsburg, W. Virginia</i>				(State) <i>WV</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Wingfield, Laurel Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAY 14 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Alvarez</i>	

## CERTIFICATE OF DEATH

MURKIN

MURKIN